INDIANA STATE BOARD OF HEALTH

89-032706

Local No. 241

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MARY R. JARRELL
2. SEX: F
3a. TIME OF DEATH: 11:05 PM
3b. DATE OF DEATH (Month, Day, Yr.): September 12, 1989
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR — Months / Days:
5c. UNDER 1 DAY — Hours / Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): Feb.-3-1916
7. BIRTHPLACE (City and State or Foreign Country): Hamilton Co In
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): HANCOCK COUNTY MEM HOSP.
9c. CITY, TOWN, OR LOCATION OF DEATH: GREENFIELD
9d. COUNTY OF DEATH: HANCOCK
10. MARITAL STATUS (Specify): WIDOWED
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOUSEWIFE
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: IN
13b. COUNTY: HENRY
13c. CITY, TOWN, OR LOCATION: KNIGHTSTOWN
13d. STREET AND NUMBER: RR#2 BOX 49
13e. ZIP CODE: 46148
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM? ☐ No ☒ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): —

PARENTS

18. FATHER'S NAME (First, Middle, Last): OSCAR ROBBINS
19. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE FOULKE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): SHARON WALKER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RR#1 BOX 6 CHARLOTTESVILLE IND
20c. Relationship: DAU

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 9-16-89 MECHANICSBURG CEMETERY
21c. LOCATION—City or Town, State: MIDDLETOWN IN
22a. EMBALMER'S NAME: GEO BALLARD JR
22b. EMBALMER'S LICENSE NO.: 01018476
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
83004586
24a. SIGNATURE OF FUNERAL DIRECTOR: Geo Ballard Jr. [signature]
24b. LICENSE NUMBER (of Licensee): 01018476
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BALLARD & SONS 118 SO 5th MIDDLETOWN IN 47356

CAUSE OF DEATH

26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. (L) Cerebral Hemisphere Embolic CVA
DUE TO (OR AS A CONSEQUENCE OF):
b. Atrial Fibrillation

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. [signature] MD
29c. MEDICAL LICENSE NO.: 01035271
29d. DATE SIGNED (Month, Day, Year): 9/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Michael D. Fletcher, M.D 11641 Fox Road Indpls, In. 46236

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D
32. DATE FILED (Month, Day, Year): September 22, 1989

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

Bk. 24-Pg. 26

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