* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 354-2002-1129-01D

State No. 041934

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): TERESA KAREN JARRELL

2 SEX: FEMALE

3a TIME OF DEATH: 4:30 AM

3b DATE OF DEATH (Month, Day, Yr): NOV. 29, 2002

4 R

5a AGE—Last Birthday (Years): 63

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo. Day, Yr): MAY 10, 1939

7 BIRTHPLACE (City and State or Foreign Country): BISMARK, N.D.

8a WAS DECEDENT A US VETERAN? NO

8b YEAR LAST SERVED IN US ARMED FORCES? NO

9a PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL

9c CITY, TOWN OR LOCATION OF DEATH: SEYMOUR

9d COUNTY OF DEATH: JACKSON

10 MARITAL STATUS (Specify): WIDOW

11 SURVIVING SPOUSE (If wife, give maiden name):

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOUSE WIFE

12b KIND OF BUSINESS/INDUSTRY: MOTHER

13a RESIDENCE—STATE: INDIANA

13b COUNTY: JACKSON

13c CITY, TOWN OR LOCATION: SEYMOUR

13d STREET AND NUMBER: 608 N. JACKSON PARK DR

13e ZIP CODE: 47274

13f INSIDE CITY LIMITS ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U.S.A.

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): WALTER BROPHY

19 MOTHER'S NAME (First, Middle, Maiden Surname): KAREN MOSS

INFORMANT

20a INFORMANT'S NAME (Type/Print): MARGARET DIANE BRICKER

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 N. Jackson Park Drive Seymour IN 47274

20c Relationship: DAUGHTER

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): December 1, 2002 Superior Crematory

21c LOCATION—City or Town, State: CHARLESTOWN IN INDIANA

22a EMBALMER'S NAME:

22b EMBALMER'S LICENSE NO.:

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Donald Mark Adams

24b LICENSE NUMBER (of Licensee): FD08600709

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Voss & Sons, 316 W. Chestnut St, Seymour IN 47274 FH83006114

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	ACUTE MYOCARDIAL INFARCTION WITH CARDIAC ARREST	FEW HOURS
DUE TO (OR AS A CONSEQUENCE OF) b	CORONARY ARTERY DISEASE	UNKNOWN
DUE TO (OR AS A CONSEQUENCE OF) c		
DUE TO (OR AS A CONSEQUENCE OF) d		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: DIABETES MELLITUS, HYPERTENSION, BRONCHOPNEUMONIA

27 WAS DECEDENT PREGNANT (OR 90 DAYS POSTPARTUM? (Yes or no)): NO

28a WAS AN AUTOPSY PERFORMED? (Yes or no): 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: W. F. Blaisdell, M.D.

29c MEDICAL LICENSE NO.: 01020748

29d DATE SIGNED (Month, Day, Year): 11/29/02

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W. F. Blaisdell, M. D., 1124 Medical Place, Seymour, IN 47274

31 HEALTH OFFICER'S SIGNATURE: Kenneth E. Bollhoff

32 DATE FILED (Month, Day, Year): Dec 2, 2002

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.