# INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1771 — CERTIFICATE OF DEATH — State No. 001236

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month,Day,Yr) |
|---|---|---|---|
| Russell Foulke | Male | 6:15am M | January 19,1999 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR Months Days | 5c. UNDER 1 DAY Hours Minutes | 6. DATE OF BIRTH (Mo. Day. Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| | 90 | | | Mar. 26,1908 | Noblesville Indiana |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See Instructions) |
|---|---|---|
| No | | HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| Riverview Hospital | Noblesville | Hamilton |

| 10. MARITAL STATUS (Specify) | 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) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Hildreth Louise Williams | Farmer | Small Business |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Hamilton | Westfield | 334 Cherry Street |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECENDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| 46074 | ☐ NO ☒ YES | ☒ NO ☐ YES | U.S.A. | ☒ NO ☐ YES (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | White | 12 | 1 |

PARENTS

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jesse Alvin Foulke | Lulu Kellam |

INFORMANT

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Norris Foulke | 11385 191st Street ~~2388 Sheridan Road~~ Noblesville, IN 46060 | Son |

DISPOSITION

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____ | January 22, 1999 Oaklawn Memorial Gardens | Fishers, IN |

| 22a. EMBALMER'S NAME: | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| J. Thomas Randall | FD01022465 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| [signature] | FD09100588 | Randall & Roberts Funeral Home 1150 Logan Street Noblesville, IN 46060 FDH3005215 |

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 Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): | |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | b Left Pleural effusion DUE TO (OR AS A CONSEQUENCE OF): | 3 months |
| | 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) |
|---|---|---|---|
| Cerebrovascular Accident | no | no | n/a |

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 | 29c. MEDICAL LICENSE NO. | 29d. DATE SIGNED (Month,Day,Year) |
|---|---|---|
| W P Beaver MD | 01025309 | 1/19/99 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

WALTER BEAVER MD 493 WESTFIELD ROAD NOBLESVILLE, IN 46060

HEALTH OFFICER

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month,Day,Year) |
|---|---|
| Charles D Harris, MD | JAN 20 1999 |

CORONER USE ONLY

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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. |
|---|---|
| | |

SDH06-004 State Form 10110-02 (R3 / 3-92)DEATHCERPD 1