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959-89

INDIANA STATE BOARD OF HEALTH

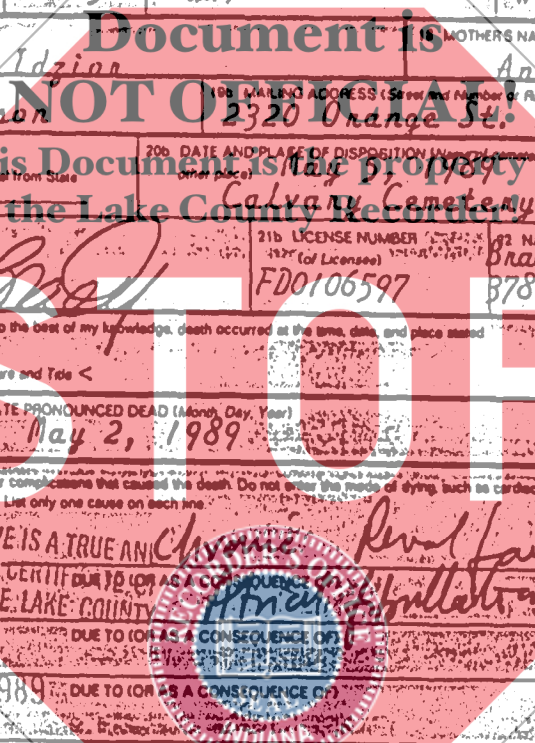
CERTIFICATE OF DEATH

Reve Hisey 2320 Orange St Lake Sta 46405 State No.

Local No.

TYPE/PRINT IN PERMANENT BLACK INK

Form with fields for DECEASED-NAME, SOCIAL SECURITY NUMBER, DATE OF BIRTH, PLACE OF BIRTH, FACILITY NAME, MARITAL STATUS, SURVIVING SPOUSE, RESIDENCE, COUNTY, CITY, TOWN OR LOCATION, STREET AND NUMBER, INSIDE CITY LIMITS, FARM, ZIP CODE, HISPANIC ORIGIN, RACE, EDUCATION, FATHER'S NAME, MOTHER'S NAME, INFORMANT, MAILING ADDRESS, RELATIONSHIP, METHOD OF DISPOSITION, DATE AND PLACE OF DISPOSITION, SIGNATURE OF FUNERAL DIRECTOR, LICENSE NUMBER OF FUNERAL HOME, NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME, TIME OF DEATH, DATE PRONOUNCED DEAD, WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER, PART I: IMMEDIATE CAUSE OF DEATH, PART II: Other significant conditions contributing to death, CERTIFIER, SIGNATURE AND TITLE OF CERTIFIER, LICENSE NUMBER, DATE SIGNED, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27, HEALTH OFFICER'S SIGNATURE, DATE FILED, MANNER OF DEATH, DATE OF INJURY, TIME OF INJURY, INJURY AT WORK, DESCRIBE HOW INJURY OCCURRED, PLACE OF INJURY, LOCATION.



FILED

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 23b MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

Vertical handwritten notes on the left margin: '8', 'Bl', '41.5', 'Sexton', '20-117-41216', 'MAY 3 1989', 'MAY 14 1990'.