

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0743-92
92074751

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Talmage Franklin Darnell Sr.		2 SEX Male	3a TIME OF DEATH 5:15p M	3b DATE OF DEATH (Month Day Yr) March 26, 1992
4 SOCIAL SECURITY NUMBER 312-09-2579	5a AGE—Last Birthday (Years) 80	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) March 5, 1912
7 BIRTHPLACE (City and State or Foreign Country) Manchester Tennessee	8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

9b FACILITY NAME (If not institution give street and number) Our Lady of Mercy		9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ruby Williams	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Hot Bed Operator	12b KIND OF BUSINESS/INDUSTRY Steel Industry
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Scherverville	13d STREET AND NUMBER 328 68th Place

PARENTS

13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian Black White etc (Specify) White	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Emergency/Secondary 12 College (1-4 or 5+) ROE 7 NOV 74 STA FILE
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INFORMANT

18 FATHER'S NAME (First Middle Last) Samuel E. Darnell	19 MOTHER'S NAME (First Middle Maiden Surname) Eupah Warren
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DISPOSITION

20a INFORMANT'S NAME (Type/Print) Ruby Darnell	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 328 68th Place Scherverville Indiana 46375	20c Relationship Wife
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory, or other place) (Month Day Year) Chapel Lawn Memorial Gardens March 30, 1992	21c LOCATION—City or Town State Scherverville Indiana

CAUSE OF DEATH

22a EMBALMER'S NAME Lawrence Miller	22b EMBALMER'S LICENSE NO. FD01006015	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR Lawrence Miller	24b LICENSE NUMBER (of Licensee) FD01006015	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen/Miller Funeral Gardens FD83003035 2828 Highway Av. Highland Indiana 46322

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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Cardiopulmonary Arrest MURDER BY CARTRIDGE DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions - Conditions contributing to death but not previously listed in Part I	Approximate Interval Between Onset and Death Seconds Months	
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) No

CERTIFIER

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time date and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 John A. Hoehn MD	29c MEDICAL LICENSE NO. 50002877	29d DATE SIGNED (Month Day Year) March 29, 1992
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. John Hoehn 2001 USRoute 41 Scherverville Indiana 46375	31 HEALTH OFFICER'S SIGNATURE Alexander Williams, MD	DATE FILED (Month Day Year) March 31, 1992
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CORONER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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			

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