

\* 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

State No. ....100849.....

Local No. ....000849.....

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

74813  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK  
10/15

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Donald J. Jarrell</b>				2. SEX <b>Male</b>		3a. TIME OF DEATH <b>12:36 P.M.</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>February 3, 1998</b>							
5a. AGE—Last Birthday (Years) <b>58</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) <b>Mar. 11, 1939</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Tipton, IN</b>							
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c. 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											
9b. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Indianapolis</b>				9d. COUNTY OF DEATH <b>MARION</b>							
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Teresa Brophy</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Machinist</b>				12b. KIND OF BUSINESS/INDUSTRY <b>Transmission Co.</b>							
13a. RESIDENCE—STATE <b>IN</b>		13b. COUNTY <b>Marion</b>		13c. CITY, TOWN, OR LOCATION <b>Indianapolis</b>				13d. STREET AND NUMBER <b>4938 West 37th St.</b>							
13e. ZIP CODE <b>46224</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>							
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>															
18. FATHER'S NAME (First, Middle, Last) <b>Paul E. Jarrell</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Katharyn Robbins</b>											
20a. INFORMANT'S NAME (Type/Print) <b>Teresa Jarrell</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4938 W. 37th St. Indpls. IN 46224</b>				20c. Relationship <b>Wife</b>							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>Feb. 6, 1998 Mechanicsburg Cemetery</b>				21c. LOCATION—City or Town, State <b>Mechanicsburg, IN</b>							
22a. EMBALMER'S NAME <b>John Almond</b>				22b. EMBALMER'S LICENSE NO. <b>FDO1009429</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes									
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) <b>860166</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Conkle Funeral Home 4925 W. 16th St. Speedway, IN 46224 FH83006423</b>									
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. <b>Acute Myocardial Infarction</b> <b>post operative period (cancer)</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last										Approximate Interval Between Onset and Death					
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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>					
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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>649-E</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-6-98</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Ronald Gemma D.O. 3731 Quion Rd. Indpls. IN</b>															
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>								32. DATE FILED (Month, Day, Year) <b>FEB - 9 1998</b>							
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.											