

INDIANA STATE DEPARTMENT OF HEALTH

001236

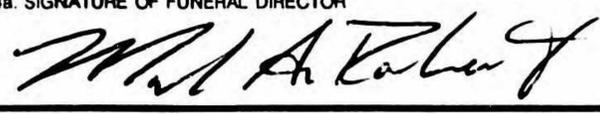
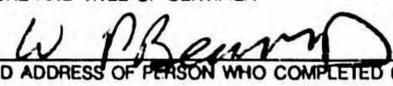
Local No. 1771

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) Russell Foulke				2. SEX Male		3a. TIME OF DEATH 6:15am M		3b. DATE OF DEATH (Month, Day, Yr) January 19, 1999			
4. SOCIAL SECURITY NUMBER		5a. AGE—Last Birthday (Years) 90		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo. Day, Yr) Mar. 26, 1908		7. BIRTHPLACE (City and State or Foreign Country) Noblesville Indiana	
8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. 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							
9b. FACILITY NAME (If not institution, give street and number) Riverview Hospital						9c. CITY, TOWN, OR LOCATION OF DEATH Noblesville			9d. COUNTY OF DEATH Hamilton		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Hildreth Louise Williams Farmer			12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)			12b. KIND OF BUSINESS/INDUSTRY Small Business			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Hamilton		13c. CITY, TOWN, OR LOCATION Westfield			13d. STREET AND NUMBER 334 Cherry Street				
13e. ZIP CODE 46074		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 DECEASED 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) White		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1	
18. FATHER'S NAME (First, Middle, Last) Jesse Alvin Foulke						19. MOTHER'S NAME (First, Middle, Maiden Surname) Lulu Kellam					
20a. INFORMANT'S NAME (Type/Print) Norris Foulke				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11385 191st Street Noblesville, IN 46060				20c. Relationship Son			
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) January 22, 1999 Oaklawn Memorial Gardens				21c. LOCATION—City or Town, State Fishers, IN			
22a. EMBALMER'S NAME: J. Thomas Randall				22b. EMBALMER'S LICENSE NO. FD01022465				23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR 				24b. LICENSE NUMBER (of Licensee) FD09100588		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Randall & Roberts Funeral Home 1150 Logan Street Noblesville, IN 46060 FDH3005215					
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. Cerebrovascular Accident						27. WAS DECEASED 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) n/a	
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 						29c. MEDICAL LICENSE NO. 01025309		29d. DATE SIGNED (Month, Day, Year) 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											
31. HEALTH OFFICER'S SIGNATURE Charles Harris, MD								32. DATE FILED (Month, Day, Year) JAN 20 1999			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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.							

DECEASED
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PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY