

INDIANA STATE BOARD OF HEALTH  
DIVISION OF VITAL STATISTICS

'PLACE OF DEATH

County of Hamilton  
Township of WashingtonLocal No. 12

## CERTIFICATE OF DEATH

3705

Town of \_\_\_\_\_

or

City of \_\_\_\_\_

(No. 1 P.R. Westfield St., \_\_\_\_\_ Ward)

State Registered No. \_\_\_\_\_

(If death occurred in a  
Hospital or Institution,  
give its NAME instead  
of street and number.)(If death occurs away from  
USUAL RESIDENCE  
give facts called for under  
"Special Information")'FULL NAME Howard Eugene Thompson

## PERSONAL AND STATISTICAL PARTICULARS

'SEX <u>Male</u>	'Color or Race <u>White</u>	'Single Married Widowed or Divorced (Write the word) <u>Single</u>
'NAME OF HUSBAND OR WIFE (of deceased)		
'DATE OF BIRTH (of deceased) <u>Jan</u> <u>5th</u> <u>1933</u> Month Day Year		
'AGE <u>0</u> years <u>0</u> months <u>3</u> days If LESS than 1 day, _____ hrs. or _____ min.?		

' OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)	<u>Infant</u>
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' BIRTHPLACE* OF DECEASED (State or country)	<u>Indiana</u>
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10 NAME OF FATHER	<u>Howard Thompson</u>
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11 BIRTHPLACE* OF FATHER (State or country)	<u>Indiana</u>
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12 MAIDEN NAME OF MOTHER	<u>Dorothea Phillips</u>
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13 BIRTHPLACE* OF MOTHER (State or country)	<u>Indiana</u>
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14 Informant (Address)	<u>Howard Thompson</u> <u>R. R. 1 - Westfield, Ind.</u>
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Burial permit issued by	<u>Frank Orans, Noblesville, Ind.</u> Health Officer or Deputy
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15 Filed	<u>Jan 9</u> 19 <u>33</u>
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) <u>Jan</u> (Day) <u>8</u> (Year) <u>1933</u>
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17 I HEREBY CERTIFY, That I attended deceased from  
Jan 5 1933 to Jan 8 1933  
that I last saw him alive on Jan 8 1933  
and that death occurred, on the date stated above, at 6 A.M.

THE CAUSE OF DEATH\* was as follows:

Incomplete Closure of Foramen  
ovale  
150-10  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Contributory  
(Secondary) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

(Signed) Dr. John P. Beck, M. D.  
1-9, 1933 (Address) Noblesville, Indiana

\*State the Disease Causing Death, or in deaths from Violent Causes state  
(1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or  
Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted,  
if not at place of death?

Former or Usual Residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Sheridan</u>	DATE OF BURIAL <u>Jan</u> 19 <u>33</u>
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20 UNDERTAKER <u>Orans &amp; Godby</u>	WAS THE BODY EMBALMED? <u>Yes</u>
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21 ADDRESS <u>Noblesville, Ind</u>	EMBALMER'S LICENSE No. <u>3229</u>
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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

A DEAD BODY BURIED WITHOUT PERMIT SHALL BE DISINTERRED AND INQUEST HELD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance.