

\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. \*

INDIANA STATE DEPARTMENT OF HEALTH

019062

Local No. 6395

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) Charles Forrest Phillips				2. SEX Male		3a. TIME OF DEATH 3:40AM		3b. DATE OF DEATH (Month Day Yr) May 27, 2004					
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) April 26, 1914		7. BIRTHPLACE (City and State or Foreign Country) Sheridan, Indiana			
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A		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									
8d. FACILITY NAME (If not institution, give street and number) Riverview Hospital						8e. CITY TOWN OR LOCATION OF DEATH Noblesville			8f. COUNTY OF DEATH Hamilton				
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Agness Clements		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Produce Manager				12b. KIND OF BUSINESS INDUSTRY Agriculture / Retail					
13a. RESIDENCE - STATE Indiana		13b. COUNTY Hamilton		13c. CITY TOWN OR LOCATION Noblesville				13d. STREET AND NUMBER 840 North 12th Street					
13e. ZIP CODE 46060		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
18. FATHER'S NAME (First, Middle, Last) Clyde Phillips						19. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Fouk							
20a. INFORMANT'S NAME (Type/Print) Charles S. Phillips				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1398 Monument Street, Noblesville, Indiana 46060				20c. Relationship Son					
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) May 31, 2004 Crown View Cemetery				21c. LOCATION - City or Town State Sheridan, Indiana					
22a. EMBALMER'S NAME Leesa M. Kercheval				22b. EMBALMER'S LICENSE NO. FDO8601527		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Morris J. Kercheval</i>				24b. LICENSE NUMBER (of Licensee) FDO1011571		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83007877 Kercheval Funeral Home P.O. Box 42; Sheridan, Indiana 46069							
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) Probable myocardial infarction 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) 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 <i>Charles Harris, MD</i>								29c. MEDICAL LICENSE NO. 01035173		29d. DATE SIGNED (Month Day Year) May 28, 2004			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Charles R. Harris M.D., 509 North Peru Street, Cicero, Indiana 46034													
31. HEALTH OFFICER'S SIGNATURE <i>Charles Harris, MD</i>										32. DATE FILED (Month Day Year) JUN 01 2004			
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.							