

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

A DEAD BODY BURIED WITHOUT A 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.

PUNCHED

Indiana State Board of Health CERTIFICATE OF DEATH

970

PLACE OF DEATH
County of Hamilton

Township of Adams

Town of _____

or
City of _____

(No. _____, St., _____ Ward)

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 John Foulk

PERSONAL AND STATISTICAL PARTICULARS

SEX Male Color or Race White Single Married Widowed or Divorced Widowed
(Write the words)

NAME OF HUSBAND OR WIFE (of deceased) _____

DATE OF BIRTH (of deceased) March 31 1844
(Month) (Date) (Year)

AGE 79 years 9 months 22 days IF LESS than 1 day, _____ hrs, or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE OF DECEASED (State or country) Ohio

NAME OF FATHER Jesse Foulk

BIRTHPLACE OF FATHER (State or country) Ohio

MAIDEN NAME OF MOTHER Mary Baker

BIRTHPLACE OF MOTHER (State or country) Penn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Foulk
(Address) Sheridan Ind

Filed 2-4 1924

Name and Address of Health Officer or Deputy
C. H. Jauch
Cicew

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 22 1924
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 18 1924 to Jan 23 1924 that I last saw him alive on Jan 22 1924 and that death occurred, on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

64
Cerebral Hemorrhage

Contributory (Secondary) What is sufficient for you
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. P. Newberry, M. D.

Jan 24 1924 (Address) Sheridan Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL

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

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

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

Former or Usual Residence _____

PLACE OF BURIAL OR REMOVAL Crown View

DATE OF BURIAL Jan 25 1924

UNDERTAKER Hinsshaw McDonald

WAS THE BODY EMBALMED? yes

ADDRESS Sheridan Ind

EMBALMER'S LICENSE No. 2290