

78-00888

78-255

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No.

TYPE OF PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE AND BOOK DECEASED RESIDENCE OF DECEASED AT TIME OF DEATH

PARENTS

SITUATION

M.D. OR D.O.

CONDITIONS WHICH GAVE RISE TO IMMEDIATE CAUSE OF DEATH

CAUSE

DECEASED - NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (MONTH, DAY, YEAR)	
1. MABEL M. GRABILL					2. FEMALE	3. MARCH 13, 1978	
RACE - (to a White, Black American Indian, etc.) (Specify)	AGE - Last Birthday (Yrs)	UNDER 1 YEAR		UNDER 1 DAY	DATE OF BIRTH (Mo, Day, Yr)	COUNTY OF DEATH	
4. WHITE	5a. 78	5b. MOS	5c. DAYS	5d. HOURS	6. 7 1 1899	7a. DELAWARE	
CITY, TOWN OR LOCATION OF DEATH				HOSPITAL OR OTHER INSTITUTION (Name if not on either, give street and number)		IF HOSP OR INST (Specify)	
7b. MUNCIE				7c. BALL MEMORIAL HOSPITAL		7d. INPATIENT	
STATE OF BIRTH (of nat in U.S.A)	CITIZEN OF WHAT COUNTRY		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		SURVIVING SPOUSE (If wife, give maiden name)		8. ARMED FORCES (Specify Year)
9. INDIANA	9. U.S.A.		10. WIDOWED		11. - - -		12. NO
SOCIAL SECURITY NUMBER			USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY		
13. 308 32 6616 A			14a. HOUSEWIFE		14b. AT HOME		
RESIDENCE - STATE		COUNTY	CITY, TOWN OR LOCATION				
15a. INDIANA		15b. DELAWARE	15c. MUNCIE				
STREET AND NUMBER					IS RESIDENCE ON A FARM?		INSIDE CITY LIMITS (Specify YES or NO)
15d. 1927 EAST 17 TH STREET					15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15f. YES
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC.							
15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
FATHER - NAME			MOTHER - MAIDEN NAME				
16. WILLIAM WORTHEN			17. MATTIE KLINGER				
INFORMANT - NAME (Type or print)				MAILING ADDRESS		CITY OR TOWN STATE ZIP	
18a. NORMA ROBBINS				18b. R. R. # 2 YORKTOWN INDIANA			
BURIAL, CREMATION, REMOVAL, OTHER (Specify)				CEMETERY OR CREMATORY - FUNERAL HOME		LOCATION CITY OR TOWN STATE	
19a. BURIAL				19b. ELM RIDGE		19c. MUNCIE INDIANA	
DATE (MONTH, DAY, YEAR)				FUNERAL HOME - NAME AND ADDRESS (STREET OR R.F.D. NO. CITY OR TOWN, STATE, ZIP)			
20a. MARCH 16, 1978				20b. MERKS MORTUARY 415 E. WASHINGTON ST. MUNCIE, IN.			
To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated					DATE SIGNED (Mo, Day, Yr)		HOUR OF DEATH
21a. (Signature) Arthur R. Boberg, M.D.					21b. MARCH 14, 1978		21c. 10:15 P
NAME OF ATTENDING PHYSICIAN (Type or Print)							
21d. ARTHUR R. BOBERG, M.D.							
MAILING ADDRESS - PHYSICIAN							
21e. 420 W. WASHINGTON ST, MUNCIE, IN.							
HEALTH OFFICER - SIGNATURE					DATE RECEIVED BY LOCAL HEALTH OFFICER		
22a. (Signature) M. D.					22b. MAR 16 1978		
23. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))							
PART I (a) Coronary Arteriosclerosis						Interval between onset and death	
DUE TO OR AS A CONSEQUENCE OF						Interval between onset and death	
(b) Arteriosclerotic Heart Disease						Years	
DUE TO OR AS A CONSEQUENCE OF						Interval between onset and death	
(c) Burchard Arteriosclerosis						Years	
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a)							
24. aged sicked cerebrovascular accident.							
AUTOPSY (Specify Yes or No)							
24. NO							

SBH 06-003 REV. 10/77

THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE WITH THE INDIANA STATE BOARD OF HEALTH

JAN 21 1981

(Signature)

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SBH 06-050 State Form 39633