

INDIANA STATE BOARD OF HEALTH
Division of Vital Records
CERTIFICATE OF DEATH

Local No: **175**
Death No: **26271**

1. PLACE OF DEATH
a. COUNTY: **MONROE**
b. CITY OR TOWN: **Bloomington**
c. LENGTH OF STAY in this place: **years**
d. FULL NAME OF HOSPITAL OR INSTITUTION: **914 East 2nd Street**

2. USUAL RESIDENCE (Where deceased lived. If institution residence to give admission)
a. STATE: **Indiana** b. COUNTY: **Monroe**
c. CITY (If outside corporate limits, write RURAL):
d. STREET ADDRESS: **914 East 2nd Street**

3. NAME OF DECEASED
a. First: **IDA** b. Middle: **May** c. Last: **KIRBY**
4. DATE OF DEATH: **Aug 26 1951**
5. SEX: **Female** 6. COLOR OR RACE: **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): **Widowed**
8. DATE OF BIRTH: **Feb. 27, 1879** 9. AGE (In years): **77**
10a. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired): **Housekeeper** 10b. KIND OF BUSINESS OR INDUSTRY: **Home**
11. BIRTHPLACE (State or foreign country): **Ohio** 12. CITIZENSHIP WHAT COUNTRY: **USA**
13. FATHER'S NAME: **Henry Carter** 14. MOTHER'S MAIDEN NAME: **Isebella Stephenson**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service): **No** 16. SOCIAL SECURITY No. (If you do not know): **Name**
17. INFORMANT (NAME AND ADDRESS): **Mrs. Etta Smith - Bloomington, Ind.**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c):
*This line and mean the mode of dying such as heart failure, asthma etc. It means the disease, injury, or complication which caused death.

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: **Acute Coronary Occlusion, Atherosclerosis**
2. ANTECEDENT CAUSES: **Senility**
3. OTHER SIGNIFICANT CONDITIONS: **Senility**

19a. DATE OF OPERATION: **None** **19b. MAJOR FINDINGS OF OPERATION:** **None**

19. AUTOPSY? Yes No

20. ACCIDENT, SUICIDE, HOMICIDE (Specify): **None**

21a. TIME OF INJURY: (Month) (Day) (Year) (Hour) (Minute)
21b. PLACE OF INJURY (e.g. in street, home, farm, factory, street, office, etc.): **None**

21c. CITY, TOWN, OR TOWNSHIP: **Bloomington** (COUNTY) (STATE)
21d. INJURY OCCURRED: While at Not While at Work at Work

21e. HOW DID INJURY OCCUR?
21f. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ from causes stated and on above date.

22a. SIGNATURE OF ATTENDING PHYSICIAN OR HEALTH OFFICER: **L. L. Schell, M.D.**
22b. ADDRESS: **Green & Farrell - Bloomington, Ind.** **22c. DATE SIGNED:**

23. BURIAL, CREMATION, REMOVAL (Specify): **Burial** **23a. DATE:** **8-29-51** **23b. NAME OF CEMETERY OR CREMATORIES:** **Rose Hill** **23c. LOCATION:** **Bloomington, Indiana**

24. DATE REC'D BY LOCAL HEALTH OFFICER: **8-30-51** **25. SIGNATURE OF HEALTH OFFICER:** **L. L. Schell, M.D.** **26. FUNERAL DIRECTOR:** **Green & Farrell - Bloomington, Ind.**

PLACE OF DEATH MEANS WHERE PERSON ACTUALLY DIED, NOT WHERE LIVED
DECEASED'S NAME: **Orville G. Green**
LICENSE NO.: **2665**
FUNERAL DIRECTOR'S LICENSE NO.: **1520**