5

Local No. 007920

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

89-046002

State No. 113 142

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: FIRST CARL MIDDLE LAST ELLIS JR. (Carl Ellis JR.)

2 SEX: M

3 DATE OF DEATH (Mo. Day. Yr.): November 25, 1989

5a AGE—Last Birthday (Years): 59

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Month, Day, Year): mar 6,1930

7 BIRTHPLACE (City and State or Foreign Country): Indianapolis, In.

8 YEAR LAST SERVED IN U.S. ARMED FORCES?: 1953

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): Methodist Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: Indianapolis

9d COUNTY OF DEATH: Marion

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Ruth A. Smither

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Plant Mgr.

12b KIND OF BUSINESS/INDUSTRY: Amer. Art. Clay

13a RESIDENCE—STATE: Indiana

13b COUNTY: Marion

13c CITY, TOWN, OR LOCATION: Indianapolis

13d STREET AND NUMBER: 2847 Tansel Rd.

13e INSIDE CITY LIMITS? (Yes or no): Yes

13f FARM: no

13g ZIP CODE: 46234

14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify: No

15 RACE—American Indian, Black, White, etc. (Specify): White

16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

40103
246

PARENTS

17 FATHER'S NAME (First, Middle, Last): Carl Ellis Sr.

18 MOTHER'S NAME (First, Middle, Maiden Surname): Millie L. Rusk

INFORMANT

19a INFORMANT'S NAME (Type/Print): Ruth A. Ellis

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2847 Tansel Rd. Indpls, In. 46234

19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☒ Other (Specify) Ent.

20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 11-28-89 Floral Park West

20c LOCATION—City or Town, State: Indianapolis, In.

21a SIGNATURE OF FUNERAL DIRECTOR: [signature]

21b LICENSE NUMBER (of Licensee): FD01005556

22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Conkle Funeral Home 4925 W. 16th St. Speedway, In. 46224 FD83006423

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <

23b LICENSE NUMBER

23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 10:02 PM

25 DATE PRONOUNCED DEAD (Month, Day, Year): November 25 1989

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) 410X a. Acute Myocardial Infarction — ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

410X

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Coronary Artery Disease — CORONARY ARTERY DISEASE 4149

28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: Andrew C. Hawk, MD

29c LICENSE NUMBER: 01036868

29d DATE SIGNED (Month, Day, Year): November 25, 1989

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): ANDREW C. HAWK, M.D. Andrew C. Hawk 1701 N. Senate Indianapolis, IN 46202

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]

32 DATE FILED (Month, Day, Year): NOV 27 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)

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