INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Local No. _____ State No. 63-006489

1. PLACE OF DEATH
a. COUNTY: Monroe
b. CITY, TOWN, OR LOCATION: Ellettsville
c. Length of Stay in lb: 2 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.R. # 1
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana b. COUNTY: Monroe
c. CITY, TOWN, OR LOCATION: Ellettsville
d. STREET ADDRESS: P.O. Box # 242
e. IS RESIDENCE INSIDE CITY LIMITS? YES ☐ NO ☒
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie Middle: Tabitha Last: Stanger
4. DATE OF DEATH: Month Day Year: 2-2-1963
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 23, 1888
9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Domestic-Worker
11. BIRTHPLACE (State or foreign country): Monroe County, Ind.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Grubb
14. MOTHER'S MAIDEN NAME: Ethel May
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. INFORMANT'S NAME: Mr. Paul Stanger
17b. INFORMANT'S ADDRESS: P.O. Box # 242 Ellettsville, Indiana
17c. RELATIONSHIP TO DECEASED: Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Accident (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension--Chronic Nephritis — 10 Yrs.
DUE TO (c) Pernicious Anemia- — 2 Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from 1960 to _____ and last saw her alive on 1/31/61. Death occurred at 1:20 P.M. (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated.
22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ M (C.S.T.) from causes stated and on above date.
23a. Signature of Attending Physician or Health Officer: C. E. Stowers, M.D.
23b. ADDRESS: Ellettsville Ind
23c. DATE SIGNED: 2-6-63
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2-5-1963
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery
24d. LOCATION: Monroe County, Ind
DATE REC'D BY LOCAL HEALTH OFFICER: 2-5-63
SIGNATURE OF HEALTH OFFICER: T. L. Wilson M.D.
25. FUNERAL DIRECTOR: Greene & Harrell Mortuary
ADDRESS: Bloomington, Indiana

FUNERAL DIRECTOR'S LICENSE No. 2035 EMBALMER'S NAME Max L. Hudson LICENSE No. 4508

S.B.H.—6-24-3—Revised 1955 U. S. Department Health, Education and Welfare. Form Approved Budget Bureau No. 68-R[illegible]