

85 046158

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

Local No. 1985-657

State No. _____

FUNERAL HOME
No. 795

FUNERAL DIRECTOR'S
LICENSE No. 2045

LICENSE No. 617

EMBALMER'S NAME G.L. Chandler, Jr.

FUNERAL DIRECTOR'S SIGNATURE G.L. Chandler

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK		DECEASED—NAME 1 Hubert E. Grubb		SEX 2 male	DATE OF DEATH (MONTH DAY YEAR) 3 Dec. 11, 1985
RACE—(e.g. White, Black, American Indian, etc.) (Specify)		AGE—Last Birthday (Yr.)	UNDER 1 YEAR MOS. DAYS HOURS MINS	DATE OF BIRTH (Mo. Day Yr.)	COUNTY OF DEATH
4 white		5a 63	5b	5c 2/10/1922	7a Monroe
CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION—(Name if not in either, give street and number)		IF HOSP OR INST indicate DOA OP (Emer. Rm. Inpatient) (Specify)	
7b Bloomington		7c Bloomington Hospital		7d inpatient	
STATE OF BIRTH (If not in U.S.A. name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If wife, give maiden name)		WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
8 Indiana	9 USA	10 N. Married		11 no	
USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY	
RESIDENCE—STATE		CITY, TOWN OR LOCATION		14b Postal Service	
15a Indiana		15c Ellettsville			
COUNTY		STREET AND NUMBER		IS RESIDENCE ON A FARM? (Specify Yes or No)	
15b Monroe		15d 1123 W. Main		15e <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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 16 William R. Grubb			MOTHER—MAIDEN NAME 17 Cora Mae Goble		
INFORMANT—NAME (Type or print)		RELATIONSHIP	MAILING ADDRESS	CITY OR TOWN	STATE ZIP
18a Robert Grubb		18b brother	18c 4660 N. Ridgewood Dr.	18d Bloomington, Ind	18e 47401
BURIAL, CREMATION, REMOVAL, OTHER (Specify)		CEMETERY OR CREMATORY—FUNERAL HOME		LOCATION CITY OR TOWN STATE	
19a Burial		19b Chambersville Cemetery		19c RR Spencer, Ind	
DATE (MONTH DAY YEAR)		FUNERAL HOME—NAME AND ADDRESS		STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP	
20a Dec. 14, 1985		20b Chandler Funeral Home Ellettsville, Ind		20c 47429	
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) <u>Allan Miller</u>		21b 12/12/85		21c 6:21 P M	
M.D. OR D.O.					
21d Allan Miller, M.D.					
MAILING ADDRESS—PHYSICIAN					
21e 619 W. 1st Street Bloomington, Ind 47401					
HEALTH OFFICER—SIGNATURE <u>Thomas W. Sharp</u>				DATE RECEIVED BY LOCAL HEALTH OFFICER	
				22b 12-17-85	
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST					
PART I		23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))		Interval between onset and death	
(a) MULTIPLE MYELOMA					
(b) DUE TO OR AS A CONSEQUENCE OF				Interval between onset and death	
(c) DUE TO OR AS A CONSEQUENCE OF				Interval between onset and death	
PART II		OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		AUTOPSY (Specify Yes or No)	
				24 no	