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

Local No. 090 76

State No. '59 028716

EMBALMER'S NAME Carl W. Matchett LICENSE No. 5124

FUNERAL DIRECTOR'S LICENSE No. 305

1. PLACE OF DEATH
a. COUNTY: Delaware
b. CITY, TOWN, OR LOCATION: Muncie
c. Length of Stay in 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ball Memorial Hospital
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana
b. COUNTY:
c. CITY, TOWN, OR LOCATION: Muncie
d. STREET ADDRESS: 210 West Memorial Drive
e. IS RESIDENCE INSIDE CITY LIMITS? YES [X] NO [ ]
f. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Bertha Middle Hendricks Last Morrison
4. DATE OF DEATH: Month Sept. Day 27 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 4/25/1881
9. AGE (In years last birthday): 78
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Hendricks
14. MOTHER'S MAIDEN NAME: Not Learned
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
17a. INFORMANT'S NAME: Fred R. Wilson
17b. INFORMANT'S ADDRESS: 105 South Gharkey St. Muncie, 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): Thrombosis, Mesenteric — INTERVAL BETWEEN ONSET AND DEATH: 10 dy
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):
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 [X]

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 1950 to 27 Sept 59 and last saw her/him alive on _____ Death occurred at 1:10 A.M. 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: Robert D. Nill
23b. ADDRESS: Yorktown Ind
23c. DATE SIGNED: 28 Sept 59

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 29, 59
24c. NAME OF CEMETERY OR CREMATORY: Beech Grove
24d. LOCATION: Muncie, Indiana

DATE REC'D BY LOCAL HEALTH OFFICER: SEP 28 1959
SIGNATURE OF HEALTH OFFICER: Charles K. Alley
25. FUNERAL DIRECTOR: Parson Mortuary
ADDRESS: Muncie, Indiana

S.B.H.—6-24-3—Revised 1958 U. S. Department Health, Education and Welfare. Form Approved Budget Bureau No. 68-R373