1041

* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 99-320

State No. 011,28

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Walter Eugene HENDRICKS

2 SEX: Male

3a TIME OF DEATH: 4:04 P M

3b DATE OF DEATH (Month, Day, Yr): September 9, 1999

5a AGE—Last Birthday (Years): 76

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo, Day, Yr): October 20, 1922

7 BIRTHPLACE (City and State or Foreign Country): Mitchell, Indiana

8a WAS DECEDENT A U.S. VETERAN? YES

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945

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

9b FACILITY NAME (If not institution, give street and number): Mitchell Manor Living and Rehab Center

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

9d COUNTY OF DEATH: Lawrence

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Barbara Thomasson

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

12b KIND OF BUSINESS/INDUSTRY: US Government

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lawrence

13c CITY, TOWN, OR LOCATION: Mitchell

13d STREET AND NUMBER: Route 4 Box 48

13e ZIP CODE: 47446

13f INSIDE CITY LIMITS ■ No ☐ Yes

13g ON A FARM? ■ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? ■ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

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

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Elijah Hendricks

19 MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Burton

INFORMANT

20a INFORMANT'S NAME (Type/Print): Barbara Hendricks

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 4 Box 98, Mitchell, Indiana 47446

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ■ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____ ☐ Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 12, 1999 Mitchell Cemetery

21c LOCATION—City or Town, State: Mitchell, Indiana

22a EMBALMER'S NAME: Gary Pruett

22b EMBALMER'S LICENSE NO: FD 01010583

23 WAS DEATH REPORTED TO CORONER? ■ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Albert D Chastain

24b LICENSE NUMBER (of Licensee): FD 01013840

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chastain Funeral Home FH 88604698, 705 West Warren Street, Mitchell, IN 47446

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms 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):
a. Non small cell carcinoma of lung — DUE TO (OR AS A CONSEQUENCE OF):
b. — DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO

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

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

CERTIFIER

29a CERTIFIER (Check only one):
■ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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) as stated.
☐ CORONER 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: Eric V. Schultz MD

29c MEDICAL LICENSE NO: 27860

29d DATE SIGNED (Month, Day, Year): September 10, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Eric V. Schultz, M. D., 1615 25th Street, Bedford, Indiana 47421

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: A. Dr. Kendrick

32 DATE FILED (Month, Day, Year): SEP 10 1999

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)

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.