

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Monroe
City or town Blettsville
(If outside city or town limits, write RURAL.)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs. or mos., or days)
Stay in this community (yrs., or mos., or days) Residential

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Indiana County Monroe
City or town Blettsville
(If outside city or town limits, write RURAL.)
Street No. (If rural give LOCATION)
2. (a) IF VETERAN, NAME YEAR

3. (a) FULL NAME

Rose Ethel Grubb

3. (b) Social Security Number

4. Sex 7 5. Color or race W. 6. (a) Single, married, widowed, or divorced widowed.

6. (b) Name of husband or wife John C. Grubb
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 6 1870

8. AGE: Years 74 Months 14 Day 18 If less than one day _____ hrs. _____ min.

9. Birthplace Monroe Co. Indiana
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William May

13. Birthplace Indiana

14. Maiden name Eliza Coffey

15. Birthplace Indiana

16. Informant Neschel Slagter

Address Blettsville, Ind.

17. Burial Date thereof 6/27/45

Cemetery or crematory Chamberlain Cem.

Location Owen Co. Ind.

18. Funeral director D. O. Button

Address Blettsville Ind.

Filed 6/26/45 R. C. Rogers
Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 6:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945 to June 22 1945 and that I last saw her alive on _____

Immediate cause of death Myocarditis

Coronary
Secondary Chronic Nephritis

Due to 93

Other conditions

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of _____
Where and injury occurred? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Injured at work? Means of injury

23. SIGNATURE L. E. Stouder
M. D. or other
Address Harport Ind. Date signed 6/22/45

DURATION
PHYSICIAN
Please underline the cause to which death should be charged statistically.

PLACE OF DEATH MEANS WHERE PERSON ACTUALLY DIED, NOT WHERE LIVED
EMBALMER'S NAME R. D. Button
LICENSE No. 1296
FUNERAL DIRECTOR'S LICENSE No. 1414