

69-025057

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

Local No. E69-104

State No. _____

PERMANENT INK
SEE HANDBOOK FOR
INSTRUCTIONS

FUNERAL HOME
No. 169
FUNERAL DIRECTOR'S
LICENSE No. 2487
FUNERAL DIRECTOR'S
SIGNATURE

DECEASED—NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (MONTH, DAY, YEAR)	
1. <u>DEONISIE CHIRILA</u>					2. <u>MALE</u>	3. <u>7/31/69</u>	
RACE	AGE—LAST BIRTHDAY (YEARS)	UNDER 1 YEAR MOS.	DAYS	UNDER 1 DAY HOURS	MIN.	DATE OF BIRTH (MONTH, DAY, YEAR)	COUNTY OF DEATH
4. <u>WHITE</u>	5a. <u>87</u>	5b.		5c.		6. <u>1/7/1882</u>	7a. <u>ELKHART</u>
CITY, TOWN, OR LOCATION OF DEATH		INSIDE CITY LIMITS (SPECIFY YES OR NO)		HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)			
7b. <u>ELKHART</u>		7c. <u>YES</u>		7d. <u>AMERICANIA NURSING CENTER</u>			
STATE OF BIRTH (IF NOT IN U.S.A.)		CITIZEN OF WHAT COUNTRY		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)	
8. <u>ROMANIA</u>		9. <u>USA</u>		10. <u>W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></u>		11. <u>ELIZABETH BOJITSA</u>	
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)		KIND OF BUSINESS OR INDUSTRY			
12. <u>RESIDENCE—STATE</u>		13a. <u>RET. DRUGLESS PHYSICIAN</u>		13b. <u>MEDICAL</u>			
14a. <u>IND.</u>		14b. <u>ELKHART</u>		14c. <u>ELKHART</u>		14d. <u>YES</u>	
STREET AND NUMBER		CITY, TOWN OR LOCATION		INSIDE CITY LIMITS (SPECIFY YES OR NO)		TOWNSHIP	
14f. <u>506 JEFFERSON ST.</u>		14g. <u>NO</u>		14e. <u>CONCORD</u>			
FATHER—NAME		FIRST	MIDDLE	LAST	MOTHER—MAIDEN NAME		
15. <u>UNK.</u>					16. <u>UNK.</u>		
INFORMANT—NAME		RELATIONSHIP		MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)			
17a. <u>ELIZABETH CHIRILA</u>		17b. <u>WIDOW</u>		17c. <u>506 JEFFERSON ST. ELKHART, IND. 46514</u>			
PART I. DEATH WAS CAUSED BY:		[ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. IMMEDIATE CAUSE		(a) <u>Cerebral thrombosis</u>					
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (A) STATING THE UNDERLYING CAUSE LAST		(b) <u>DUE TO, OR AS A CONSEQUENCE OF:</u>					
		(c) <u>DUE TO, OR AS A CONSEQUENCE OF:</u>					
PART II. OTHER SIGNIFICANT CONDITIONS GIVEN IN PART I (A)		CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE				AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						19a. <u>NO</u>	
						IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH 19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DATE & TIME OF DEATH		MONTH	DAY	YEAR	HOUR	DATE SIGNED	MONTH DAY YEAR
20. <u>7 31 1969 6:10p.m.</u>						21a. <u>8-1-69</u>	
PHYSICIAN'S NAME (TYPE OR PRINT)		SIGNATURE OF PHYSICIAN				(DEGREE OR TITLE)	
22a. <u>OLAN D. FEAR MD.</u>		22b. <u>Olaf D. Fear</u>				<u>M.D.</u>	
MAILING ADDRESS—PHYSICIAN		STREET OR R.F.D. NO.		CITY OR TOWN		STATE ZIP	
23. <u>303 S. NAPPANEE ST. ELKHART, IND. 46514</u>							
BURIAL, CREMATION, REMOVAL (SPECIFY)		CEMETERY, CREMATORY, FUNERAL HOME		LOCATION		CITY OR TOWN STATE	
24a. <u>BURIAL</u>		24b. <u>RICE CEMETERY</u>		24c. <u>ELKHART, INDIANA</u>			
DATE (MONTH, DAY, YEAR)		FUNERAL HOME—NAME AND ADDRESS				(STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)	
24d. <u>8/2/1969</u>		25a. <u>W.M. STEMM FUNERAL HOME 214 DIVISION ST. ELKHART, IND. 46514</u>					
25b. <u>SBH 6-24-2</u>		HEALTH OFFICER'S SIGNATURE				DATE RECEIVED BY LOCAL HEALTH OFFICER	
		26b. <u>August 9, 1969</u>					