

8. 2 DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS INDIANA STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS Local No. **10891** Registered No. **5291**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH: **349**  
 County **Morgan**  
 City or town **Indianapolis 511**  
 Street address, hospital, or institution: **1040 West Michigan St. Ill. Med. Bldg.**  
 Stay in hospital or inst. (yrs. or mos., or days) **2 days**  
 Stay in this community (yrs. or mos., or days) **0**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State **Indiana** County **Madison**  
 City or town **Indianapolis**  
 Street No. **1639 S. M. St.**  
 (If rural give LOCATION)  
 2. (c) IF VETERAN, NAME WAR **K48-1**

3. (a) FULL NAME **CASTLE TIER Edwin** 3. (b) Social Security Number

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

6. (b) Name of husband or wife **Irene Castetter** 6. (c) If alive, give age **33** years

7. Birth date of deceased (mo., day, yr.) **3 March 1910**

8. AGE: Years **35** Months **11** Days **11** If less than one day: hrs. min.

9. Birthplace **Hancock County Ind**  
 (Town, county and state)

10. Usual occupation **Factory worker**

11. Industry or business **Detroit Army**

12. Name **EDWIN CASTLE TIER**

13. Birthplace **Indianapolis Indiana**

14. Maiden name **FLOSSIE BYERS**

15. Birthplace **Indiana**

16. Informant **Mrs Irene Castetter**  
 Address **Elwood Ind**

17. **Burial** Date thereof **2-27-47**  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory **City**  
 Location **Church**

18. Funeral director **M. M. York**  
 Address **Elwood**

Filed **Feb 27 1947** **Donald F. Kempf** Health Officer

MOTHER FATHER  
 FUNERAL DIRECTOR'S LICENSE No. **11-2-4**  
 EXEMPTER'S NAME **Edwin J. J. J.**  
 LICENSE No. **7025**

PLACE OF DEATH MEANS WHERE PERSON ACTUALLY DIED, NOT WHERE LIVED

MEDICAL CERTIFICATION

20. DATE OF DEATH **20 Feb 1947** at **8:28 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **2:30 P.M. 19** to **2:35** 19 **47** and that I last saw him alive on **20 Feb** 19 **47**

Immediate cause of death **Chronic myocardial**  
 Due to **hypertension**  
 Due to **atherosclerosis of the coronary arteries**  
 Other conditions **heart disease**  
 (Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Injured at work? Means of injury \_\_\_\_\_

23. SIGNATURE **Edwin J. J. J.** M. D. or other  
 Address **111 West Center St. No 703**

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