Qc

* 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. 05-526 State No. 018686

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased—Name (First, Middle, Last)	Ina M. Henderson
2. Sex	Female
3a. Time of Death	06:45 PM
3b. Date of Death (Month, Day, Yr)	May 21, 2005
4. *Social Security Number	
5a. Age—Last Birthday (Years)	91
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	December 21, 1913
7. Birthplace (City and State or Foreign Country)	Fishers, IN
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in US Armed Forces?	N/A
9a. Place of Death	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name	Elm Croft Living Center
9c. City, Town, or Location of Death	Muncie
9d. County of Death	Delaware
10. Marital Status	Widowed
11. Surviving Spouse (If wife, give maiden name)	N/A
12a. Decedent's Usual Occupation	Laborer
12b. Kind of Business/Industry	Automotive
13a. Residence—State	Indiana
13b. County	Delaware
13c. City, Town, or Location	Muncie
13d. Street and Number	1601 N. Morrison Rd
13e. Zip Code	47304
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	U.S.A
15. Was Decedent of Hispanic Origin?	☒ No ☐ Yes
16. Race	Caucasian
17. Decedent's Education	Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	Oscar Robins
19. Mother's Name (First, Middle, Maiden Surname)	Grace Foulke

INFORMANT

Field	Value
20a. Informant's Name	Walter Robbins
20b. Mailing Address	8400 W. CR 400 S; Yorktown, IN 47396
20c. Relationship	Brother

DISPOSITION

Field	Value
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition	MAY 24, 2005 Gardens of Memory
21c. Location—City or Town, State	Muncie, IN
22a. Embalmer's Name	Lyndal Ray Wolf
22b. Embalmer's License No	FD20200090
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD20200090
25. Name, Address, and License Number of Funeral Home	Garden View Funeral Home (Lic. # FH19800019) 10501 North State Road 3; Muncie, IN 47303

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

	Cause
a. Immediate cause (Final disease or condition resulting in death)	Rheumatoid Arthritis
b. Due to (or as a consequence of)	Arteriosclerosis
c. Due to (or as a consequence of)	Hypothyroidism
d. Due to (or as a consequence of)	Failure to thrive at age 91

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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

Field	Value
27. Was Decedent Pregnant or 90 Days Postpartum?	No
28a. Was an Autopsy Performed?	No
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death?	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

Field	Value
29b. Signature and Title of Certifier	M.D. [signature]
29c. Medical License No	01035957
29d. Date Signed	5/24/05
30. Name and Address of Person Who Completed Cause of Death (Item 26)	Mohammed Bahrami; 1420 S Pilgrim Blvd; Yorktown, IN 47396

HEALTH OFFICER

Field	Value
31. Health Officer's Signature	Donna A. Wilkins MD
32. Date Filed	MAY 26 2005

Field	Value
33. Manner of Death	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. Date of Injury	
34b. Time of Injury	
34c. Injury at Work?	
34d. Describe How Injury Occurred	
34e. Place of Injury	
34f. Location	
34g. Date Pronounced Dead	
34h. Motor Vehicle Accident?	

SDH06-004 State Form 10110 (R5/1-99)

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