



# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. <u>0009461</u>		State No. <u>035895</u>	
1. Decedent's Legal Name (First, Middle, Last) <b>Herschel J. Musick</b>		2. Sex <b>Male</b>	3. Time of Death <b>10:09 am</b>
4. Date of Death (Month/Day/Year) <b>Sept 23, 2008</b>		5. Date of Birth (Month/Day/Year) <b>May 7, 1923</b>	
6. Birthplace (City And State Or Foreign Country) <b>Daleville, IN</b>		7. Date of Birth (Month/Day/Year) <b>May 7, 1923</b>	
8a. Age - Yrs <b>85</b>		8b. Under 1 Year <b>Months</b>	
8c. Under 1 Month <b>Days</b>		8d. Under 1 Day <b>Hours</b>	
8e. Under 1 Hour <b>Minutes</b>		8f. Under 1 Minute <b>Seconds</b>	
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival	
11. Facility Name (If Not Institution, Give Street And Number) <b>Ball Memorial Hospital</b>		12. City Or Town, State, and Zip Code <b>Muncie IN 47303</b>	
13. County Of Death <b>Delaware</b>		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name <b>N/A</b>		16a. (If Wife) Give Maiden Last Name <b>N/A</b>	
16b. Decedent's Usual Occupation <b>Machine operator</b>		17. Kind Of Business/Industry <b>Manufacturing</b>	
18. Residence - State <b>Indiana</b>		18a. County <b>Delaware</b>	
18b. City Or Town <b>Daleville</b>		18c. Apt. No. <b>14921 West 4rth</b>	
18d. Zip Code <b>47334-</b>		18e. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education <b>9</b>		20. Decedent Of Hispanic Origin <b>N/A</b>	
21. Decedent's Race <b>White</b>		22. Father's Name (First, Middle, Last) <b>Abraham Musick</b>	
23. Mother's Name (First, Middle, Last) <b>Blanche A. Musick</b>		24. Mother's Maiden Last Name <b>Unknown</b>	
25. Informant's Name <b>Mark Musick</b>		26. Relationship To Decedent <b>Son</b>	
27. Mailing Address (Street And Number, City, State, Zip Code) <b>6242 South CR 675 E Plainfield, IN 46168-</b>		28. Place Of Disposition <b>Park View Cemetery</b>	
29. Location - City, Town, And State <b>Alexandria, Indiana</b>		30. Location - City, Town, And State <b>Alexandria, Indiana</b>	
31. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		32. Name And Complete Address Of Funeral Facility <b>Ballard &amp; Sons Funeral Home, Inc. 8212 South Walnut Street Daleville IN 47334</b>	
33. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>		34. License Number (Of Licensee) <b>01018476</b>	
35. Cause Of Death (See Instructions And Examples) 28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Pneumonia</u> B. <u>Coronary Heart Failure</u> C. <u>Chronic Obstructive Pulmonary Disease</u> D. <u>Myocardial Infarction</u> Approximate Interval: Onset To Death <u>1 wk</u> <u>1 wk</u> Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I <u>Hypertension, Hyperlipidemia, Chronic Obstructive Pulmonary Disease</u> 29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year 33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined 34. Date Of Injury (Month/Day/Year) 35. Time Of Injury 36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) 37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 38. Location Of Injury - State 38a. City Or Town 38b. Street & Number 38c. Apt. No. 38d. Zip Code 39. Describe How Injury Occurred 40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) 41. Signature Of Person Certifying Cause Of Death: <i>Kimberly R. Mauler, MD</i> 42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer 43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>Kimberly R. Mauler, MD, 3631 N. Morrison Rd Suite 200 Muncie IN 47304</b> 44. License Number <b>01047281</b> 45. Date Certified <b>9/30/08</b> 46. Additional Funeral Service Provider: 47. *Ann: 48. Signature Of Local Health Officer: <i>Ann L. Dinning</i> 49. For Registrar Only - Date & Time Of Registration <b>SEP 30 2008</b>			

State Form 10110 (R7/8-07) ATTENTION: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Do not enter a country and there will be no penalty for failure to do so. THE REGISTERS OF THIS BUREAU ARE CLOSED TO THE PUBLIC.

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