

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Below for State Office Use

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MORRIS T. KERCHEVAL

1157

EMBALMER'S NAME

LICENSE No.

1270

FUNERAL DIRECTOR'S LICENSE No.

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

State
No.

U-032783

Local No.

241

1. PLACE OF DEATH a. COUNTY <u>Hamilton</u>		2. USUAL RESIDENCE (Where deceased lived, at institution, residence before admission) b. STATE <u>Indiana</u> c. COUNTY <u>Hamilton</u>	
b. CITY, TOWN, OR LOCATION <u>Rt. 1 Arcadia, Ind.</u>		c. Length of Stay in lb <u>11 yrs.</u>	c. CITY, TOWN, OR LOCATION <u>Rt. 1 Arcadia</u>
d. NAME OF HOSPITAL OR INSTITUTION <u>Rt. 1 Arcadia</u>		d. STREET ADDRESS	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Phillips</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1883</u>
9. AGE (In years, months, and days) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Foulke</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Underwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17a. INFORMANT'S NAME <u>Mrs. Leon Pickett</u>	
17b. INFORMANT'S ADDRESS <u>Rt. 1 Arcadia, Indiana</u>		17c. RELATIONSHIP TO DECEASED <u>Daughter</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Curvature of the spine</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>years</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>5:05</u> a.m. <u>P</u> Month <u>9</u> Day <u>20</u> Year <u>1963</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK AT WORK		20f. CITY, TOWN, OR LOCATION <u>Sheridan, Ind.</u>	
20g. COUNTY <u>Sheridan</u>		20h. STATE <u>Ind.</u>	
21. ATTENDING PHYSICIAN: I certify that I attended the deceased from <u>1960</u> to <u>1963</u> and last saw him alive on <u>Sept 15, 1963</u> at <u>5:05 P</u> M (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated.		22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at <u>Sheridan, Ind.</u> (C.S.T.) from causes stated and on above date.	
23a. Signature of Attending Physician or Health Officer. <u>Paul W. M.D.</u>		23b. ADDRESS <u>Sheridan, Ind.</u>	
23c. DATE SIGNED <u>9-18-63</u>		23d. NAME OF CEMETERY OR CREMATORY <u>Crown View Cem.</u>	
23e. LOCATION <u>Sheridan, Ind.</u>		23f. DATE REC'D BY LOCAL HEALTH OFFICER <u>9-20-63</u>	
23g. SIGNATURE OF HEALTH OFFICER <u>A. F. Connors</u>		23h. FUNERAL DIRECTOR <u>Hinshaw Funeral Home</u>	
23i. ADDRESS <u>Sheridan, Ind.</u>		23j. DATE SIGNED <u>9-20-63</u>	