

12/13

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

Below for State Office Use

A 49X

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M.R.

EMBALMER'S NAME Robert D. Papert
LICENSE No. 1127
MEDICAL CERTIFICATION
FUNERAL DIRECTOR'S LICENSE No. 1905

2981

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

59 020020

Local No. _____ State No. _____

1. PLACE OF DEATH
a. COUNTY MARION
b. CITY, TOWN, OR LOCATION INDIANAPOLIS c. Length of Stay in lb 23 DAYS
d. NAME OF HOSPITAL OR INSTITUTION METHODIST HOSPITAL d. STREET ADDRESS 2958 FOLTZ
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES NO e. IS RESIDENCE INSIDE CITY LIMITS? YES NO f. IS RESIDENCE ON A FARM? YES NO

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE INDIANA b. COUNTY MARION
c. CITY, TOWN, OR LOCATION INDIANAPOLIS

3. NAME OF DECEASED (Type or print) First Middle Last MINNIE MAE STETZEL 4. DATE OF DEATH Month Day Year JUNE 25 1959

5. SEX F 6. COLOR OR RACE W 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH 10/10/83 9. AGE (In years last birthday) Months Days Hours Min. 75 8 13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) MISSOURI 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME WILLIAM H. KRIGBAUM 14. MOTHER'S MAIDEN NAME ELIZABETH DANFORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, so, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. No 17a. INFORMANT'S NAME FERN GRIFFEY

17b. INFORMANT'S ADDRESS 3250 DAVIS DRIVE, INDIANAPOLIS, IND. 17c. RELATIONSHIP TO DECEASED DAUGHTER

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE
5810 DUE TO (b) BILIARY CIRRHOSIS
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY Hour Month Day Year a. m. p. m. _____

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from 6/2/59 to 6/25/59 and last saw (but) alive on 6/25/59. Death occurred at 11:35 P.M. (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated. DANIEL E. MCLAREN MD

22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ (C.S.T.) from causes stated and on above date. _____

23a. Signature of Attending Physician or Health Officer Samuel E. McCarren MD 23b. ADDRESS Methodist Hospital 23c. DATE SIGNED 6/25/59

24a. BURIAL, CREMATION, REMAINS (Specify) Burial 24b. DATE 6-29-59 24c. NAME OF CEMETERY OR CREMATORY Floral Park Indpls, Ind. 24d. LOCATION _____

DATE REC'D BY LOCAL HEALTH OFFICER JUN 24 1959 SIGNATURE OF HEALTH OFFICER Henry J. Hatakeyama 25. FUNERAL DIRECTOR Farley F. Home - Indianapolis Ind

88-11-1-21-3 Revised 1955 U. S. Department Health, Education and Welfare. Form Approved Budget Bureau No. 68-837