

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**INDIANA STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH**

36403

1. PLACE OF DEATH

County Davis
 Township Wagon
 City Wagon (No. _____)

Registration District No. 253
 Primary Registration District No. 5353

File No. 16
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If nonresident give city or town and State)

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17-1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	81	6	9	5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Flat Rock Ind
(STATE OR COUNTRY)

10. NAME OF FATHER Mike Mason

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Eizabeth Shopp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Penn
(STATE OR COUNTRY)

14. INFORMANT Mrs Elmer Woolsey
(Address) Brekenridgemw.

15. FILED Dec 27 1927 A.G. Minich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 22 1927

17. I HEREBY CERTIFY, That I attended deceased from December 14th, 1927, to Dec. 21, 1927, that I last saw him alive on Dec. 21, 1927, and that death occurred, on the date stated above, at 3 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Brights Disease
1295 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Physical Appearance
 (Signed) Chas J Moore, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Crosser Cemetery DATE OF BURIAL Dec 25 1927

20. UNDERTAKER Flat Rock Breckenridgemw
ADDRESS

