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RECORD

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EMBALMER'S NAME Robert Gurley
LICENSE No. 5365

FUNERAL DIRECTOR'S LICENSE No. 1828

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

State No. 59 042718

Local No. 1584

1. PLACE OF DEATH a. COUNTY <u>Vanderburgh</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Vand.</u>	
b. CITY, TOWN, OR LOCATION <u>Evansville</u>		c. Length of Stay in 1b	c. CITY, TOWN, OR LOCATION <u>Evansville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kueber Nursing Home</u>		d. STREET ADDRESS <u>Kueber Nursing Home</u>	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wesley</u> Last <u>Gibson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Ma.</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 1865</u>
9. AGE (In years last birthday) <u>94</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Turman W. Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Amanda G. Randel</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. Robert R. Acre</u>	
17b. INFORMANT'S ADDRESS <u>2311 Lincoln Ave. Evansville, 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>General arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 yrs</u>
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
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 <u>June 1958</u> to <u>Dec 21 1959</u> and last saw her/him alive on <u>Dec 21 1959</u> . Death occurred at <u>3:45 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 _____ M (C.S.T.) from causes stated and on above date.	
23a. Signature of Attending Physician or Health Officer. <u>Robert R. Acre M.D.</u>		23b. ADDRESS <u>2311 Lincoln Ave. Evansville, Ind.</u>	23c. DATE SIGNED <u>12/21/59</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-24-1959</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	24d. LOCATION <u>Indianapolis, Ind.</u>
DATE REC'D BY LOCAL HEALTH OFFICER <u>12-22-59</u>	SIGNATURE OF HEALTH OFFICER <u>C. E. French M.D.</u>	25. FUNERAL DIRECTOR ADDRESS <u>Lowe Funeral Chapel, Evansville</u>	