

THE DIVISION OF HEALTH OF INDIANA  
STANDARD CERTIFICATE OF DEATH

**6119**  
**1111**

State File No. ....  
Registrar's No. ....

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **4002**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		a. STATE <b>Indiana</b> b. COUNTY <b>Parke</b>	
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>Rockville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>R. R. # 4</b>		<b>813 1/2</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>William</b>	b. (Middle) <b>Adam</b>	c. (Last) <b>Earl</b>	(Month) <b>February</b>	(Day) <b>2</b>	(Year) <b>1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 18, 1916</b>	9. AGE (In years last birthday) <b>37</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>William Earl Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Lizzie Belle Cox.</b>	14. NAME OF HUSBAND OR WIFE <b>Beulah Earl.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wm. Earl Sr.</b> ADDRESS <b>Rockville, Indiana.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>METASTATIC CANCER OF LIVER AND BONE</b>		DUPLICATE OF (a) <b>METASTATIC CANCER OF LIVER AND BONE</b>		<b>5 MONTHS</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		<b>11 MONTHS</b>
		DUPLICATE OF (b) <b>CANCER OF PANCREAS</b>		
		DUPLICATE OF (c)		
		II. OTHER SIGNIFICANT CONDITIONS		
		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>157X</b>

22. I hereby certify that I attended the deceased from 1/7, 1954, to 2/2, 1954, that I last saw the deceased alive on 2/2, 1954 and that death occurred at 11:30<sup>a</sup> m., from the causes and on the date stated above.

23a. SIGNATURE <b>James S. Michael</b> (Degree or title) <b>M. D.</b>	23b. ADDRESS <b>Barnes Hospital</b>	23c. DATE SIGNED <b>2/2/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-2-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memory Garden Cem.</b>
		24d. LOCATION (City, town, or county) (State) <b>Rockville, Indiana.</b>

DATE REC'D BY LOCAL REG. <b>FEB 4 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington.</b>
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*1-5412* (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.