

AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE INDIANA b. COUNTY MARION				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS			Length of stay in 1b 1 MONTH		c. CITY OR TOWN INDIANAPOLIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1919a SULLIVAN				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3046 COLORADO		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRONA CAROLINE VIRDEN			4. DATE OF DEATH Month Day Year 1-23-1961					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-17-1891	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) FRANCISCO, IND.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM HALWES			13b. MOTHER'S MAIDEN NAME ANNA AHRENE		14. NAME OF HUSBAND OR WIFE OTTO VIRDEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. not available		17. INFORMANT Address WILLIAM VIRDEN 1919a SULLIVAN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH 2 years	
IMMEDIATE CAUSE (a)			Coronary Insufficiency					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Arteriosclerotic Heart Disease					
			DUE TO (c) 420.0 H					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of the Vulva						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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. I attended the deceased from 12-14-60 to 1-23-61 and last saw her alive on 1-23-61				Death occurred at approximately 3A m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) Fred J. Sherman M.D.			22b. ADDRESS 630 S. Kingshighway		22c. DATE SIGNED 1-24-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/23/61	23c. NAME OF CEMETERY OR CREMATORY ODDFELLOWS		23d. LOCATION (City, town, or county) FRANCISCO IND.		(State)	
24. FUNERAL DIRECTOR Lamb & Son Oakland City, Ind.			ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 23 1961	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.		

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 Mr. Embarked Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed George Casady III

Licensed Embalmer No. 5039

P. O. Address E. St. Louis, Mo.

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.