30884

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 000125 State No. 92-002217

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Gladys Bates Messer
2 SEX: Female
3a TIME OF DEATH: 7:25P M
3b DATE OF DEATH (Month, Day, Yr.): January 4,1992
5a AGE—Last Birthday (Years): 87
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): December 23,1904
7 BIRTHPLACE (City and State or Foreign Country): unknown, Kentucky
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: ---
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Vincent's Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Indianapolis
9d COUNTY OF DEATH: Marion
10 MARITAL STATUS (Specify): Widowed
11 SURVIVING SPOUSE (If wife, give maiden name): ---
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Department Head
12b KIND OF BUSINESS/INDUSTRY: P.L. Polk & Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Marion
13c CITY, TOWN, OR LOCATION: Indianapolis
13d STREET AND NUMBER: 4811 Round Lake Rd #C
13e ZIP CODE: 46205
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc (Specify): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

21600 246

PARENTS

18 FATHER'S NAME (First, Middle, Last): Martin Bates
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Larke

INFORMANT

20a INFORMANT'S NAME (Type/Print): Bobbie J. Hood
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4459 Washington Blvd, Indpls,IN 46205
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 9,1992 Rest Haven Cemetery
21c LOCATION—City or Town, State: Evendale,OH
22a EMBALMER'S NAME: Brian K. Miller
22b EMBALMER'S LICENSE NO: 9000040
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 1020675
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Flanner & Buchanan 3003297 1305 E. Broad Ripple,Indpls,IN 46220

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): 586X
a Uremia
DUE TO (OR AS A CONSEQUENCE OF)
b UREMIA
DUE TO (OR AS A CONSEQUENCE OF)
c
DUE TO (OR AS A CONSEQUENCE OF)
d

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

586X

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: 486X P neumonia PNEUMONIA; 5339 Peptic ulcer disease PEPTIC ULCER DISEASE
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a WAS AN AUTOPSY PERFORMED? (Yes or no)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a CERTIFIER (Check only one): ☑ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
29b SIGNATURE AND TITLE OF CERTIFIER: Kenneth W Beckley
29c MEDICAL LICENSE NO: 01028542
29d DATE SIGNED (Month, Day, Year): 1/9 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Kenneth W. Beckley, M.D.
Kenneth Beckley 3330 Hoss Rd Indianapolis Indiana

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month, Day, Year): JAN 8 1992

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g DATE PRONOUNCED DEAD (Month, Day, Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1