ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

002696

Local No. 5

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

6cc 1411

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Wilburn Ray Ellis
2. SEX: Male
3a. TIME OF DEATH: 2:54 PM
3b. DATE OF DEATH (Month, Day, Yr.): January2, 1998
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Oct. 8, 1918
7. BIRTHPLACE (City and State or Foreign Country): Holladay, TN
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary's Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Evansville
9d. COUNTY OF DEATH: Vanderburgh
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marie Fortner
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Farmer
12b. KIND OF BUSINESS/INDUSTRY: Agriculture
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Saline
13c. CITY, TOWN, OR LOCATION: Harrisburg
13d. STREET AND NUMBER: 375 Ellis Farm Lane
13e. ZIP CODE: 62946
13f. INSIDE CITY LIMITS: [X] No [ ] Yes
13g. ON A FARM?: [ ] No [X] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 8 1; College (1-4 or 5 +): 0

PARENTS

18. FATHER'S NAME (First, Middle, Last): Giles Vick Ellis
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Bond

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jim Ellis
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1250 Ellis Rd Harrisburg, IL
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 6, 1998 Raleigh Masonic Cemetery
21c. LOCATION—City or Town, State: Raleigh, IL
22a. EMBALMER'S NAME: Steven L. Austin
22b. EMBALMER'S LICENSE NO.: FDO8601381
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Carol K. York Boone Funeral Home, IN Agent
24b. LICENSE NUMBER (of Licensee): FDO1015347
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Reed Funeral Chapel 503 E. Sloan Harrisburg, IL

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)	a. Acute Cerebellar Stroke	Days
	DUE TO (OR AS A CONSEQUENCE OF): b.	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: Rhonda Eubanks MD
29c. MEDICAL LICENSE NO.: 01042768
29d. DATE SIGNED (Month, Day, Year): 1/5/98

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Rhonda Eubanks, MD 801 St. Mary's Medical Center Evansville, IN 47714
31. HEALTH OFFICER'S SIGNATURE: John A. Heidinger Gibbs, MD
32. DATE FILED (Month, Day, Year): JAN - 7 1998

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.