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

CERTIFICATE OF DEATH

Local No. 32-505-94 ..... State No. 94-044998

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	Rita H. Knight
2 SEX	Female
3a TIME OF DEATH	10:35P M
3b DATE OF DEATH (Month, Day, Yr)	November 23, 1994
5a AGE—Last Birthday (Years)	73
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo, Day, Yr)	Dec. 27, 1920
7 BIRTHPLACE (City and State or Foreign Country)	Punxsutawney, PA
8a WAS DECEDENT A US VETERAN?	yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1943
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	Brownsburg Health Care Center
9c CITY, TOWN, OR LOCATION OF DEATH	Brownsburg
9d COUNTY OF DEATH	Hendricks
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)	owner
12b KIND OF BUSINESS/INDUSTRY	Card & Gift Shop
13a RESIDENCE—STATE	Indiana
13b COUNTY	Hendricks
13c CITY, TOWN, OR LOCATION	Brownsburg
13d STREET AND NUMBER	1010 Hornaday Rd.
13e ZIP CODE	46112
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+)	—

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Isaac Hamilton
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Alexandrina Sani

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Dee Fortlage
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	924 St. Andrews Dr. Plainfield, IN 46168
20c Relationship	daughter

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☐ Burial ☒ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	November 26, 1994 American Midwest Crematory
21c LOCATION—City or Town, State	Indianapolis, IN
22a EMBALMER'S NAME	none
22b EMBALMER'S LICENSE NO	n/a
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Steven S Matthews (signature)
24b LICENSE NUMBER (of Licensee)	FDO1001667
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Matthews Mortuary FH83000621 402 E. Main St. Brownsburg, IN 46112

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Alzheimers type dementia	
DUE TO (OR AS A CONSEQUENCE OF) b		
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

Field	Entry
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)

- ☒ 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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Angela Johnson (signature)
29c MEDICAL LICENSE NO	01035146
29d DATE SIGNED (Month, Day, Year)	11/28/94
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	3580 Lafayette Rd #C2A Indpls Angela Johnson

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	(signature)
32 DATE FILED (Month, Day, Year)	11-29-94

Field	Entry
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.	

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1