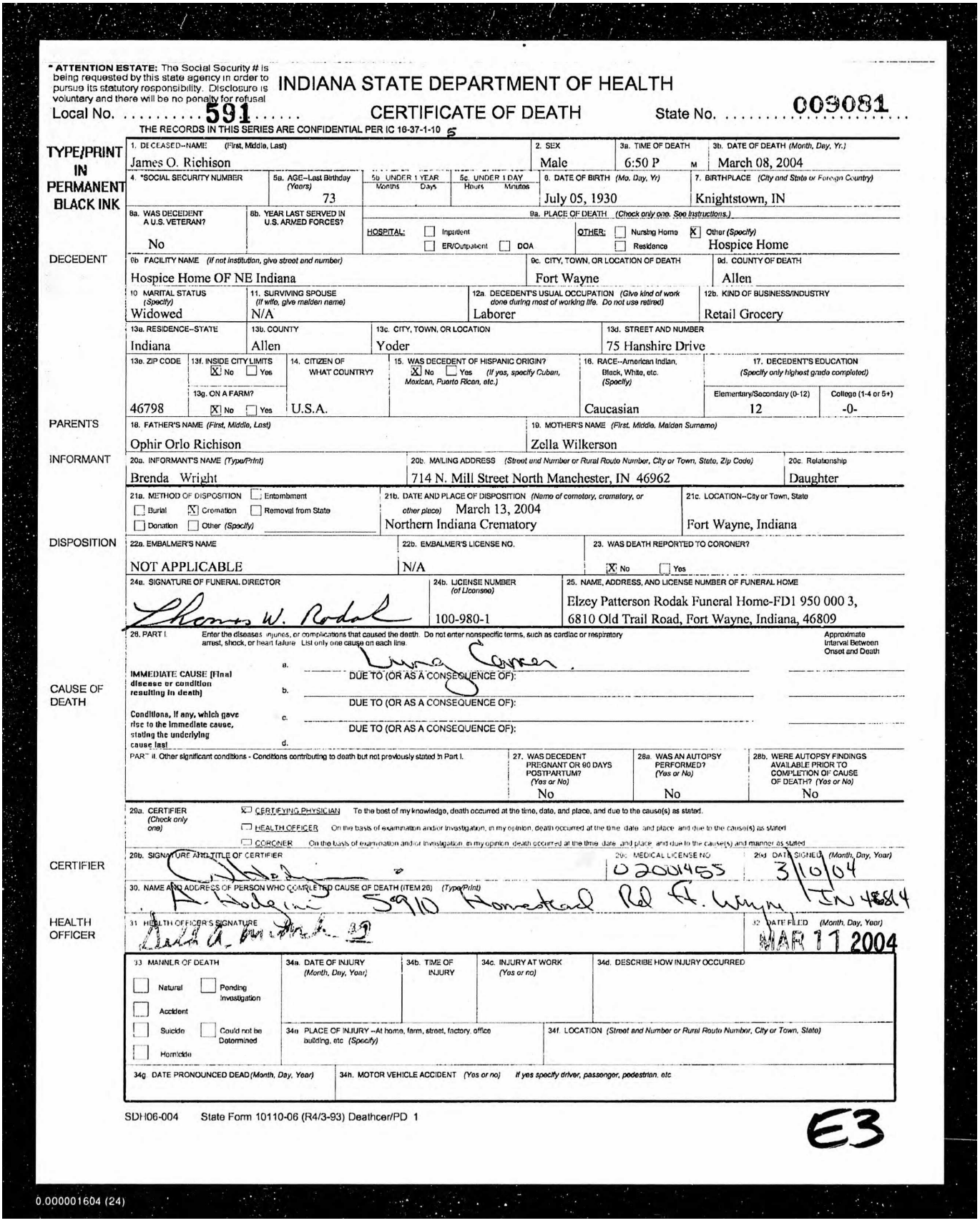
"Indiana, Death Certificates, 1899-2011," digital images, *Ancestry.com* (http://www.ancestry.com : accessed 24 July 2016); James O. Richison (8 March 2004), Certificate of Death no. 009081, Allen County; citing Death Certificates, 1900-2011, microfilm, Indianapolis.



* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 591

CERTIFICATE OF DEATH

State No. 009081

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 5

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First, Middle, Last): James O. Richison
2. SEX: Male
3a. TIME OF DEATH: 6:50 P M
3b. DATE OF DEATH (Month, Day, Yr.): March 08, 2004
4. *SOCIAL SECURITY NUMBER:
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): July 05, 1930
7. BIRTHPLACE (City and State or Foreign Country): Knightstown, IN
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 ☐ Residence ☒ Other (Specify) Hospice Home
9b. FACILITY NAME (If not institution, give street and number): Hospice Home OF NE Indiana
9c. CITY, TOWN, OR LOCATION OF DEATH: Fort Wayne
9d. COUNTY OF DEATH: Allen
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b. KIND OF BUSINESS/INDUSTRY: Retail Grocery
13a. RESIDENCE--STATE: Indiana
13b. COUNTY: Allen
13c. CITY, TOWN, OR LOCATION: Yoder
13d. STREET AND NUMBER: 75 Hanshire Drive
13e. ZIP CODE: 46798
13f. INSIDE CITY LIMITS ☒ No ☐ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE--American Indian, Black, White, etc. (Specify): Caucasian
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): -0-

PARENTS

18. FATHER'S NAME (First, Middle, Last): Ophir Orlo Richison
19. MOTHER'S NAME (First, Middle, Maiden Surname): Zella Wilkerson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Brenda Wright
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 714 N. Mill Street North Manchester, IN 46962
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 13, 2004 Northern Indiana Crematory
21c. LOCATION--City or Town, State: Fort Wayne, Indiana
22a. EMBALMER'S NAME: NOT APPLICABLE
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas W. Rodak
24b. LICENSE NUMBER (of Licensee): 100-980-1
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Elzey Patterson Rodak Funeral Home-FD1 950 000 3, 6810 Old Trail Road, Fort Wayne, Indiana, 46809

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. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
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): 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:
29c. MEDICAL LICENSE NO: 02001455
29d. DATE SIGNED (Month, Day, Year): 3/10/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A. Sodagini 5910 Homestead Rd Ft. Wayne IN 46814

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): MAR 11 2004

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 10110-06 (R4/3-93) Deathcer/PD 1

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