"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

Local No. 80 CH6 198 — **CERTIFICATE OF DEATH** — State No. 94-038125

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Jack W. Barnett			2 SEX: Male	3a TIME OF DEATH: 3:00 AM	3b DATE OF DEATH (Month, Day, Yr): Sept. 10, 1994
5a AGE—Last Birthday (Years): 33	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo. Day, Yr): Mar. 1, 1961		7 BIRTHPLACE (City and State or Foreign Country): Evansville IN
8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? —	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☒ Other (Specify): Motel ☐ Residence		
9b FACILITY NAME (If not institution, give street and number): Four Seasons Motel Hwy 62 W.		9c CITY, TOWN, OR LOCATION OF DEATH: Mt. Vernon		9d COUNTY OF DEATH: Posey	
10 MARITAL STATUS (Specify): divorced	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): auxilliary equip. oper		12b KIND OF BUSINESS/INDUSTRY: SIGECO	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Warrick	13c CITY, TOWN, OR LOCATION: Chandler		13d STREET AND NUMBER: 6833 Maple Drive	
13e ZIP CODE: 47610	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+):				

PARENTS

18 FATHER'S NAME (First, Middle, Last): Larry Barnett	19 MOTHER'S NAME (First, Middle, Maiden Surname): Janice L. Jones

INFORMANT

20a INFORMANT'S NAME (Type/Print): Jeff Barnett	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RR #1 Lynnville IN 47619	20c Relationship: brother

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sept. 12, 1994 Alexander Memorial Park	21c LOCATION—City or Town, State: Evansville IN	
22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR: Ann M. Hallund	24b LICENSE NUMBER (of Licensee): FD08600327	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bradley's Col. Chapel 80300798 1005 E Main Boonville IN 47601	

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	SELF INFICTED GUN SHOT WOUND THRU	INSTANT
DUE TO (OR AS A CONSEQUENCE OF) b	ROOF OF MOUTH.	
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF) c		
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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	Yes	Yes

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	29d DATE SIGNED (Month, Day, Year)
Ted M Moore, Posey Co. Coroner		9-12-94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Mr. Ted Moore 737 E. Church St., New Harmony, IN 47631

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Herman Hirsch M.D.	9/12/94

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☒ Suicide ☐ Could not be Determined ☐ Homicide	9-10-94	3 AM	NO	SELF INFICTED GUNSHOT TO ROOF MOUTH

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)
Hwy 62 W. Mt. Vernon IN. 47620	Four Seasons Motel

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
9-10-94	No

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