Indiana State Board of Health

CERTIFICATE OF DEATH 26714

PUNCHED

Registered No. .....

[If death occurred in a Hospital or Institution, give its NAME instead of street and number.]

(No. ..... ; ..... St., ... Ward)

¹PLACE OF DEATH

County of LaGrange

Township of Bloomfield

Town of LaGrange

or City of .....

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

²FULL NAME Wesley Coloska Comble

PERSONAL AND STATISTICAL PARTICULARS

³SEX: Male

⁴Color of Race: White

⁵Single, Married, Widowed or Divorced (Write the Word): Married

⁶NAME OF HUSBAND OR WIFE (of deceased): Susanna A. Comble

⁷DATE OF BIRTH (of deceased): April (Month) 4 (Date) 1849 (Year)

⁸AGE: 72 years, 5 months, 14 days. If LESS than 1 day, ... hrs. or ..... min.?

⁹OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

¹⁰BIRTHPLACE OF DECEASED (State or country): Indiana

PARENTS

¹¹NAME OF FATHER: Wm Comble

¹²BIRTHPLACE OF FATHER (State or country): Ohio

¹³MAIDEN NAME OF MOTHER: Mary Jane Sama

¹⁴BIRTHPLACE of MOTHER (State or country): Indiana

¹⁵I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lucama Comble
(Address) LaGrange Indiana

¹⁶Filed 10/3, 19 22
Archie Jones
Name and Address of Health Officer or Deputy

MEDICAL CERTIFICATE OF DEATH

¹⁷DATE OF DEATH: September (Month) 19 (Day) 1922 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1921 to September 19, 1922 that I last saw h[illegible] alive on September 19, 1922 and that death occurred, on the date stated above, at 905 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage and Uremic Toxemia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary): Sedentary Habits

(Duration) ..... yrs ..... mos ..... ds.

(Signed) Archie Jones, M.D.
Sept 20, 1922 (Address) LaGrange Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

¹⁸LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or Usual Residence .....

¹⁹PLACE OF BURIAL OR REMOVAL: Jackson Grave — DATE OF BURIAL: Sept 22, 1922

²⁰UNDERTAKER: Caton Bros — WAS THE BODY EMBALMED? Yes

²¹ADDRESS: LaGrange Indiana — EMBALMER'S LICENSE No. 865