

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Dr. William Kane
8525 Broadway
State *Marionville*
No.

636079
64-1309

Local No.

1. PLACE OF DEATH a. COUNTY Lake		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Lake	
b. CITY, TOWN, OR LOCATION Gary		c. CITY, TOWN, OR LOCATION Gary	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 617 W. 43rd Place		d. STREET ADDRESS 617 W. 43rd Place	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle CAMPBELL Last MYERS		4. DATE OF DEATH Month 10 Day 12 Year 1964	
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintaince		10b. KIND OF BUSINESS OR INDUSTRY Sheet & Tin Mill	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17b. INFORMANT'S ADDRESS 617 W. 43rd Place, Gary, Ind		17a. INFORMANT'S NAME Mrs. Minnie Myers	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Coronary Arteriosclerosis Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		17c. RELATIONSHIP TO DECEASED WILLIAM BIELSKI JUL 19 12 04 PM '61 RECORDED INTERNAL BETWEEN INSET AND DEATH SEARCHED INDEXED SERIALIZED FILED 1961 8 AUDITOR LAKE COUNTY	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Schererville, Ind	
21. ATTENDING PHYSICIAN: I certify that I attended the deceased from 1940 to 10-12-64 and last saw him alive on 8-22-64 Death occurred at 9:45 P M (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated.		22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ M (C.S.T.) from causes stated and on above date.	
23a. Signature R. Malton May <input type="checkbox"/> Health Officer <input checked="" type="checkbox"/> Attending Physician		23b. ADDRESS	
23c. DATE SIGNED		24. NAME OF CEMETERY OR CREMATORY Chapel Lawn	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-15-1964	
24c. NAME OF CEMETERY OR CREMATORY Chapel Lawn		24d. LOCATION Schererville, Ind	
25. FUNERAL DIRECTOR		ADDRESS Gary, Ind	

DR PREPARED BY INK S IS A ANENT CORP State Use

43-253-15 Add. L. 13

Octave General

EMBALMER'S NAME **James King** LICENSE No. **218**

MEDICAL CERTIFICATION

FUNERAL DIRECTOR'S LICENSE No. **2124**

Funeral Permit Provisional

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CERTIFIED COPY

R. J. Rosenblom, M.D.
HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE OCT. 14 1964