

657020

# INDIANA STATE BOARD OF HEALTH CORONER'S CERTIFICATE OF DEATH

State No. \_\_\_\_\_

Local No. 6-82

TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

JAN 21 1982

FUNERAL HOME

No. of \_\_\_\_\_

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

PARENTS

DISPOSITION

CERTIFIER

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

DECEASED—NAME FIRST MIDDLE LAST <b>Harold S. Walker</b>		SEX 2 <b>Male</b>	DATE OF DEATH (MONTH, DAY, YEAR) 3 <b>January 3, 1982</b>
RACE—(a) White, Black, American Indian, etc. (Specify) 4 <b>White</b>	AGE—Last Birthday (Mo.) (Da.) (Hr.) (Mn.) 5a <b>54</b>	UNDER 1 YEAR 6a. MONTHS 6b. DAYS	UNDER 1 DAY 6c. HOURS 6d. MINUTES
CITY, TOWN OR LOCATION OF DEATH 7a <b>Lowell</b>	HOSPITAL OR OTHER INSTITUTION—(Name if not in either, give street and number) 7c <b>16208 Wicker</b>	DATE OF BIRTH (Mo., Day, Yr.) 8 <b>Oct. 19, 1927</b>	COUNTY OF DEATH 7b <b>Lake</b>
STATE OF BIRTH (If not in U.S.A. name country) 9 <b>Indiana</b>	CITIZEN OF WHAT COUNTRY 10 <b>U.S.A.</b>	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 11 <b>Married</b>	SURVIVING SPOUSE (If not, give maiden name) 12 <b>Dorothy Mc Intosh</b>
SOCIAL SECURITY NUMBER 13 <b>703-07-5129</b>	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a <b>Ironworker</b>	KIND OF BUSINESS OR INDUSTRY 14b <b>Construction</b>	
RESIDENCE—STATE 15a <b>Indiana</b>	COUNTY 15b <b>Lake</b>	CITY, TOWN OR LOCATION 15c <b>Lowell</b>	IS RESIDENCE ON A FARM? 15d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
STREET AND NUMBER 15e <b>16208 Wicker</b>		IS RESIDENCE ON A FARM? 15d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INSIDE CITY LIMITS (Specify YES OR NO) 15f <b>Yes</b>
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FATHER—NAME FIRST MIDDLE LAST 16 <b>Ivan Walker</b>		MOTHER—MAIDEN NAME FIRST MIDDLE LAST 17 <b>Leora Mc Connell</b>	
INFORMANT—NAME (Type or Print) 18a <b>Dorothy Walker (Wife)</b>		MAILING ADDRESS—STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 18b <b>16208 Wicker Lowell, Indiana 46356</b>	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a <b>Burial</b>	CEMETERY OR CREMATORY—FUNERAL HOME 19b <b>Chapel Lawn</b>	LOCATION CITY OR TOWN STATE 19c <b>Schererville, Indiana 46303</b>	
DATE (MONTH, DAY, YEAR) 20a <b>January 6, 1982</b>	FUNERAL HOME—NAME AND ADDRESS—(STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 20b <b>Eller Brady 8510 Lakeshore Dr., Cedar Lake, Ind/</b>		
On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the causal stated.		DATE SIGNED (Mo., Day, Yr.) 21b <b>1-5-82</b>	HOUR OF DEATH 21c <b>6:50 P.M.</b>
CERTIFIER (Type or Print) 21a. Signature <b>Albert T. Willard, M.D.</b> NAME AND ADDRESS OF CERTIFIER (Type or Print) 21f. <b>ALBERT T. WILLARD, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307</b>		PRONOUNCED DEAD (Mo., Day, Yr.) 21d. ON <b>1-3-82</b>	PRONOUNCED DEAD (Hour) 21e. AT <b>6:50 P.M.</b>
HEALTH OFFICER—SIGNATURE 22a <b>Albert T. Willard, M.D.</b>		DATE RECEIVED BY LOCAL HEALTH OFFICER 22b <b>1-5-82</b>	
IMMEDIATE CAUSE 23 <b>Laceration of brain stem</b>		Interval between onset and death <b>Undetermined</b>	
DUE TO OR AS A CONSEQUENCE OF (a) <b>Due to shotgun wound</b>		Interval between onset and death	
DUE TO OR AS A CONSEQUENCE OF (b)		Interval between onset and death	
DUE TO OR AS A CONSEQUENCE OF (c)		Interval between onset and death	
OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not listed in cause given in PART I (List)		AUTOPSY (Specify Yes or No) 24 <b>Yes</b>	
ACC. SUICIDE, HOMICIDE, UNDETERMINED OR PENDING INVEST. (Specify) 25a <b>Suicide</b>	DATE OF INJURY (Mo., Day, Yr.) 25b	HOUR OF INJURY 25c <b>M</b>	DESCRIBE HOW INJURY OCCURRED 25d <b>Gunshot wound</b>
INJURY AT WORK (Specify Yes or No) 25e <b>No</b>	PLACE OF INJURY—(As home, farm, school, factory, where building, etc. (Specify) 25f <b>Home</b>	LOCATION—STREET OR R.F.D. NO. CITY OR TOWN STATE 25g <b>16208 Wicker, Lowell, IN.</b>	

FILED  
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Disposition Permit Issued / /  
Provisional Certificate  
 Yes  No

EMBALMER'S NAME  
FUNERAL DIRECTOR'S SIGNATURE

LAKE COUNTY HEALTH COMMISSION  
CERTIFIER  
Albert T. Willard, M.D.

STATE OF INDIANA  
CLERK OF SUPERIOR COURT  
RECORDED  
JAN 24 PM '82

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