

TYPE OR PRINT

INDIANA STATE BOARD OF HEALTH CORONER'S CERTIFICATE OF DEATH

State No. _____

Local No. **8-0703**
669 364

DATE OF DEATH (MONTH, DAY, YEAR)
9-12-81

DECEASED—NAME
FIRST MIDDLE LAST
William Rickman

SEX
M

RACE—White, Black, American Indian, etc. (Specify)
B

AGE—Last Birthday (Yrs.)
73

UNDER 1 YEAR UNDER 1 DAY
MOSE. DAYS HOURS MINES.
6-3-08

DATE OF BIRTH (Mo., Day, Yr.)
6-3-08

COUNTY OF DEATH
LAKE

CITY, TOWN OR LOCATION OF DEATH
GARY

HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number)
2174 Kentucky

IF HOSP. OR INST. Indicate DOA, OP, Emer. Rm., Inpatient (Specify)
7d.

STATE OF BIRTH (If not in U.S. name country)
ILL

CITIZEN OF WHAT COUNTRY
U.S.

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
MARRIED

SURVIVING SPOUSE (If wife, give maiden name)
yes

WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
yes

SOCIAL SECURITY NUMBER
359-05-4586

USUAL OCCUPATION (Give kind of work done during most of working life, when it retired)
Retired

KIND OF BUSINESS OR INDUSTRY
U.S. Steel

RESIDENCE—STATE
Ind

COUNTY
LAKE

CITY, TOWN OR LOCATION
GARY

IS RESIDENCE ON A FARM?
15a. YES NO

INSIDE CITY LIMITS (SPECIFY YES OR NO)
Yes

STREET AND NUMBER
2174 Kentucky

IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC.
15g. YES NO

FATHER—NAME FIRST MIDDLE LAST
UNKNOWN

MOTHER—MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN

PERMANENT NAME RELATIONSHIP MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP
Beatrice Lowe 2174 Kentucky GARY

DISPOSITION BURIAL CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN STATE ZIP
BURIAL EVERGREEN 39 Sanducky GARY

DATE (MONTH, DAY, YEAR) FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)
9-15-81 Codrington 934 E. 21st Ave

DATE SIGNED (Mo., Day, Yr.)
9-22-81

HOUR OF DEATH
11:05 A.

PRONOUNCED DEAD (Mo., Day, Yr.)
9-12-81

PRONOUNCED DEAD (Hour)
11:05 A.

21b. Signature **Albert T. Willardo, M.D.**
NAME AND ADDRESS OF CERTIFIER (Type or Print)
ALBERT T. WILLARDO, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER—SIGNATURE
S. A. Caldwell, M.D.

DATE RECEIVED BY LOCAL HEALTH OFFICER
SEP 22 1981

23. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))
Cardio vascular pulmonary failure

DUE TO, OR AS A CONSEQUENCE OF:
Due to arteriosclerotic heart & vascular disease

DUE TO OR AS A CONSEQUENCE OF
Undetermined

PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to causes given in PART I (a)
24. No

ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)
25a. Natural

DATE OF INJURY (Mo., Day, Yr.) HOUR OF INJURY DESCRIBE HOW INJURY OCCURRED
25b. 25c. M 25d.

INJURY AT WORK (Specify Yes or No) PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE
25e. 25f. 25g.

READING INK
THIS IS A
PERMANENT
RECORD
for State Office Use

FUNERAL HOME
No. **23**

FUNERAL DIRECTOR'S
LICENSE No. **657**

FILED

PARENTS
1982
MAR 6

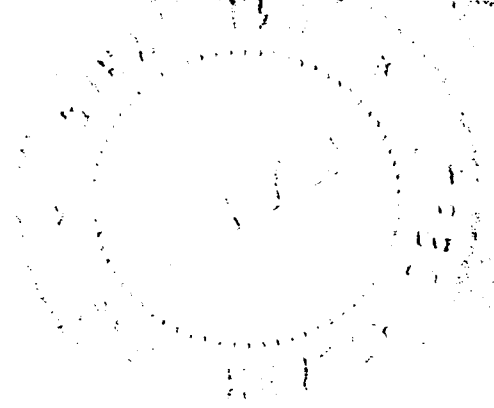
CERTIFIER

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

CAUSE

Disposition Permit issued / /
Provisional Certificate Yes No
Brownard Spent A \$ 25 10.17
S. 15' of S. 24' 2.17
Buy # 45-99-26

EMBALMER'S NAME
Charles Smith
FUNERAL DIRECTOR'S SIGNATURE
Charles Smith



45-99-24

CERTIFIED COPY
E. N. Caldwell, M.D.
 HEALTH COMMISSIONER
 CITY OF GARY, IND.
 DATE SEP 22 1981

