

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

7cc  
675224

INDIANA STATE BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

State  
No.

Local No. 631-82

TYPE  
OR PRINT  
IN  
PERMANENT  
INK  
FOR  
INSTRUCTIONS  
SEE  
HANDBOOK

|                                                                                                                      |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
|----------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|-------------------------------------------------------------------|
| DECEASED - NAME                                                                                                      |                              | FIRST                  | MIDDLE                                              | LAST                                                                                   | SEX                                          | DATE OF DEATH (MONTH DAY YEAR)                 |                                                                   |
| 1                                                                                                                    |                              | CHARLES                | J.                                                  | FORSYTHE                                                                               | Male                                         | April 23, 1982                                 |                                                                   |
| RACE - (e.g. White, Black, American Indian, etc.) (Specify)                                                          | AGE - (Last birthday) (Year) | UNDER 1 YEAR           |                                                     | UNDER 1 DAY                                                                            |                                              | DATE OF BIRTH (Mo. Day Yr.)                    | COUNTY OF DEATH                                                   |
| 4 White                                                                                                              | 5a 81                        | 5b                     | 5c                                                  | 6 Sept. 8, 1900                                                                        |                                              | 7a Lake                                        |                                                                   |
| CITY, TOWN OR LOCATION OF DEATH                                                                                      |                              |                        |                                                     | HOSPITAL OR OTHER INSTITUTION - (Name if not in other place street and number)         |                                              |                                                | IF HOSP OR INST. Indicate DOA, OP, Inst. Rm., Treatment (Specify) |
| 7b Merrillville                                                                                                      |                              |                        |                                                     | 7c Methodist Hospital Southlake Campus                                                 |                                              |                                                | 7d Inpatient                                                      |
| STATE OF BIRTH (If not in U.S.A. Name (Specify))                                                                     | CITIZEN OF WHAT COUNTRY      |                        | MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) |                                                                                        | SURVIVING SPOUSE (If wife, give maiden name) |                                                | WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)       |
| 8 Illinois                                                                                                           | 9 U.S.A.                     |                        | 10 Married                                          |                                                                                        | 11 Frances E. McGinnis                       |                                                | 12 No                                                             |
| SOCIAL SECURITY NUMBER                                                                                               |                              |                        |                                                     | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                                              | KIND OF BUSINESS OR INDUSTRY                   |                                                                   |
| 13 306-10-0044                                                                                                       |                              |                        |                                                     | 14a Superintendent of Transportation                                                   |                                              | 14b Shoreline Bus Co.                          |                                                                   |
| RESIDENCE - STATE                                                                                                    | COUNTY                       | CITY, TOWN OR LOCATION |                                                     |                                                                                        |                                              |                                                |                                                                   |
| 15a Indiana                                                                                                          | 15b Lake                     | 15c Gary               |                                                     |                                                                                        |                                              |                                                |                                                                   |
| STREET AND NUMBER                                                                                                    |                              |                        |                                                     | IS RESIDENCE ON A FARM?                                                                |                                              | INSIDE CITY LIMITS (Specify Yes or No)         |                                                                   |
| 15d 3945 Washington Street                                                                                           |                              |                        |                                                     | 15a YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |                                              | 15f Yes                                        |                                                                   |
| 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                                                                                   | MOTHER - MAIDEN NAME                         |                                                | FIRST                                                             |
| 16                                                                                                                   |                              | James                  |                                                     | Forsythe                                                                               | 17                                           |                                                | Janie White                                                       |
| INFORMANT - NAME (If not at home)                                                                                    |                              |                        | RELATIONSHIP                                        | MAILING ADDRESS                                                                        |                                              | CITY OR TOWN                                   | STATE ZIP                                                         |
| 18a Frances E. Forsythe                                                                                              |                              |                        | 18b -Wife                                           | 18c 3945 Washington Street                                                             |                                              | 18d Gary, Indiana                              | 18e 46408                                                         |
| BURIAL, CREMATION, REMOVAL, OTHER (Specify)                                                                          |                              |                        |                                                     | CEMETERY OR CREMATORY - FUNERAL HOME                                                   |                                              | LOCATION                                       |                                                                   |
| 19a Burial                                                                                                           |                              |                        |                                                     | 19b Ridgeland Cemetery                                                                 |                                              | 19c Gary, Indiana                              |                                                                   |
| DATE (MONTH, DAY, YEAR)                                                                                              |                              |                        |                                                     | FUNERAL HOME - NAME AND ADDRESS                                                        |                                              | (STREET OR R.F.D. NO. CITY OR TOWN STATE, ZIP) |                                                                   |
| 20a April 27, 1982                                                                                                   |                              |                        |                                                     | 20b Geisen Funeral Home, Inc., 7905 Broadway, Merr., In. 46410                         |                                              |                                                |                                                                   |
| To the best of my knowledge death occurred (Write time, date and place and due to the causal event)                  |                              |                        |                                                     | DATE SIGNED (Mo., Day, Yr.)                                                            |                                              | HOUR OF DEATH                                  |                                                                   |
| 21a (Signature) <i>Raymond P. Doherty</i>                                                                            |                              |                        |                                                     | 21b April 26, 1982                                                                     |                                              | 21c 1:25 P.                                    |                                                                   |
| NAME OF ATTENDING PHYSICIAN (Type or Print)                                                                          |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
| 21d Raymond Doherty M.D.                                                                                             |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
| MAILING ADDRESS - PHYSICIAN                                                                                          |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
| 21e 8695 Connection Street                                                                                           |                              |                        |                                                     | Merrillville, Indiana 46410                                                            |                                              |                                                |                                                                   |
| HEALTH OFFICER - SIGNATURE                                                                                           |                              |                        |                                                     | DATE RECEIVED BY LOCAL HEALTH OFFICE                                                   |                                              |                                                |                                                                   |
| 22a <i>[Signature]</i>                                                                                               |                              |                        |                                                     | 22b 4-26-82                                                                            |                                              |                                                |                                                                   |
| CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE - STATING THE UNDERLYING CAUSE LAST                             |                              |                        |                                                     | PART I                                                                                 |                                              |                                                |                                                                   |
| 23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a) AND (b))                                                   |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
| (a) <i>Myocardial Infarction</i>                                                                                     |                              |                        |                                                     | Interval between onset and death                                                       |                                              |                                                |                                                                   |
| (b) <i>Arterio Sclerosis</i>                                                                                         |                              |                        |                                                     | Interval between onset and death                                                       |                                              |                                                |                                                                   |
| (c)                                                                                                                  |                              |                        |                                                     |                                                                                        |                                              |                                                |                                                                   |
| PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a) |                              |                        |                                                     | AUTOPSY (Specify Yes or No)                                                            |                                              |                                                |                                                                   |
| 24                                                                                                                   |                              |                        |                                                     | No                                                                                     |                                              |                                                |                                                                   |

Below for State Office

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2nd Addition  
# 42-235-19  
THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPT. IN FILE WITH THE LAKE COUNTY HEALTH DEPT.

EMBALMER'S NAME  
FUNERAL DIRECTOR'S SIGNATURE  
WILLIAM B. BROWN

FILED  
JUN 19 1982  
DECEASED  
GENERAL DIRECTOR'S LICENSE NO. 336  
APR 26 1982  
WILLIAM B. BROWN  
LAKE COUNTY HEALTH COMMISSIONER

USUAL RESIDENCE OF DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION  
PARENTS  
DISPOSITION  
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE - STATING THE UNDERLYING CAUSE LAST  
CAUSE

400