TYPE OR PRINT 675241 Local No. 11/65 - 380

INDIANA STATE BOARD OF HEALTH
CORONER'S CERTIFICATE OF DEATH

State No. 2 H. Clifford

789

PLAINLY WITH UNFADING INK
THIS IS A PERMANENT RECORD

Below for State Office Use

A
B
C
D
E
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I
J
K
L

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Margaret Stookey
2. SEX	Female
3. DATE OF DEATH (Month, Day, Year)	October 27, 1980
4. RACE	White
5a. AGE—Last Birthday (Yrs)	73
5b. UNDER 1 YEAR (Mos, Days)	
5c. UNDER 1 DAY (Hours, Mins)	
6. DATE OF BIRTH (Mo, Day, Yr)	8-27-1907
7a. COUNTY OF DEATH	Lake
7b. CITY, TOWN OR LOCATION OF DEATH	Hobart
7c. HOSPITAL OR OTHER INSTITUTION	2111 W. 49th Avenue
7d. IF HOSP. OR INST.	————
8. STATE OF BIRTH (If not in U.S.A. name country)	Ireland
9. CITIZEN OF WHAT COUNTRY	U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	Widowed
11. SURVIVING SPOUSE	None
12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	no
13. SOCIAL SECURITY NUMBER	304-22-8646
14a. USUAL OCCUPATION	Home-maker
14b. KIND OF BUSINESS OR INDUSTRY	None
15a. RESIDENCE—STATE	Indiana
15b. COUNTY	Lake
15c. CITY, TOWN OR LOCATION	Hobart
15d. STREET AND NUMBER	2111 W. 49th Avenue
15e. IS RESIDENCE ON A FARM?	YES ☐ NO ☒ XXX
15f. INSIDE CITY LIMITS	yes
15g. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC.	YES ☐ XXX

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

PARENTS

Field	Entry
16. FATHER—NAME	James Neill (deceased)
17. MOTHER—MAIDEN NAME	Margaret Gordon (deceased)
18a. INFORMANT—NAME / RELATIONSHIP	Dr. Richard D. Stookey / son
18b. MAILING ADDRESS	2107 W. 49th Ave., Hobart, IN 46342

DISPOSITION

Field	Entry
19a. BURIAL, CREMATION, REMOVAL, OTHER	Burial
19b. CEMETERY OR CREMATORY—FUNERAL HOME	Calumet Park Cemetery
19c. LOCATION	Merrillville, IN 46342
20a. DATE (Month, Day, Year)	10-29-1980
20b. FUNERAL HOME—NAME AND ADDRESS	Rees Funeral Home, Inc., 600 W. Ridge Rd. Hobart,

CERTIFIER

On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.

Field	Entry
21a. Signature	A. Williardo, MD
21b. DATE SIGNED (Mo, Day, Yr)	10-29-80
21c. HOUR OF DEATH	M
21d. PRONOUNCED DEAD (Mo, Day, Yr) ON	10-27-80
21e. PRONOUNCED DEAD AT	11:35 AM
21f. NAME AND ADDRESS OF CERTIFIER	ALBERT T. WILLIARDO, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN 46307
22a. HEALTH OFFICER (Signature)	Fred Pearcy M.D.
22b. DATE RECEIVED BY LOCAL HEALTH OFFICER	11-10-80

CAUSE

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

23. (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

	Cause	Interval between onset and death
PART I (a) IMMEDIATE CAUSE	Cardio vascular pulmonary failure	Undetermined
(b) DUE TO, OR AS A CONSEQUENCE OF:		
(c) DUE TO OR AS A CONSEQUENCE OF:		
PART II OTHER SIGNIFICANT CONDITIONS		

24. AUTOPSY: No

Field	Entry
25a. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST.	Natural
25b. DATE OF INJURY	
25c. HOUR OF INJURY	M
25d. DESCRIBE HOW INJURY OCCURRED	
25e. INJURY AT WORK	
25f. PLACE OF INJURY	
25g. LOCATION	

FUNERAL HOME No. 306

FUNERAL DIRECTOR'S LICENSE No. 1575

LICENSE No. 2012

EMBALMER'S NAME: K. Gudds

FUNERAL DIRECTOR'S SIGNATURE

FILED JUL 20 1982

AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH DEPT.

Disposition Permit Issued / /

Provisional Certificate ☐ Yes ☐ No

SBH-06-004 REV. 10/77