

*Dawson & Keenak  
P.O. Box 3217  
East Chicago*

# INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

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

Local No. 864-83

**718534**

1. DECEASED—NAME <b>James M. McKinnie</b>		2. SEX <b>Male</b>	3. DATE OF DEATH (MONTH, DAY, YEAR) <b>5/30/83</b>
4. RACE—(e.g. White, Black, American Indian, etc.) <b>BLK.</b>	5a. AGE—Last Birthday (Yrs) <b>84</b>	5b. UNDER 1 YEAR MOS. DAYS	5c. UNDER 1 DAY HOURS MINS
6. CITY, TOWN OR LOCATION OF DEATH <b>MUNSTER</b>		7a. COUNTY OF DEATH <b>LAKE</b>	
7b. STATE OF BIRTH (If not in U.S.A. name country) <b>ILLINOIS</b>		7c. HOSPITAL OR OTHER INSTITUTION—(Name if not in either, give street and number) <b>MUNSTER MED. INN</b>	
8. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	10. SURVIVING SPOUSE (If under, give maiden name) <b>MARTHA POWELL</b>	
11. SOCIAL SECURITY NUMBER <b>314-20-0759</b>		12. IF HOSP. OR INST. Indicate DDA, OP, Emer. Rm., Inpatient (Specify) <b>INPATIENT</b>	
13. USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION		14. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) <b>NO</b>	
15a. RESIDENCE—STATE <b>INDIANA</b>	15b. COUNTY <b>LAKE</b>	15c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>	
16. CITY, TOWN OR LOCATION <b>EAST CHICAGO</b>		14b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANERS</b>	
17. STREET AND NUMBER <b>3905 DRUMMOND</b>		15d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15e. INSIDE CITY LIMITS (Specify Yes or No) <b>YES</b>
18. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19. FATHER—NAME FIRST MIDDLE LAST <b>MONROE Mc KENNIE</b>		20. MOTHER—MAIDEN NAME FIRST MIDDLE LAST <b>HATTIE TAYLOR</b>	
21. INFORMANT—NAME (If type or grade) RELATIONSHIP <b>MARTHA McKinnie</b>		22. MAILING ADDRESS (STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP) <b>3905 DRUMMOND EAST CHICAGO, INDIANA</b>	
23. BURIAL, CREMATION, REMOVAL, OTHER (Specify) <b>BURIAL</b>		24. CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN STATE <b>EVERGREEN HOBART, INDIANA</b>	
25. DATE (MONTH, DAY, YEAR) <b>JUNE 4, 1983</b>		26. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE ZIP) <b>DENNIS FUNERAL HOME 3820 PULASKI EAST CHICAGO, IND.</b>	
27. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 28. (Signature)		29. DATE SIGNED (M., Day, Yr.) <b>5/31/83</b>	30. HOUR OF DEATH <b>9:30 P.M.</b>
31. NAME OF ATTENDING PHYSICIAN (If type or grade) <b>Dr. Gaddipati M.D.</b>			
32. MAILING ADDRESS—PHYSICIAN <b>7935 Calmet Av., Mn., IN. 46321</b>			
33. HEALTH OFFICER—SIGNATURE 		34. DATE RECEIVED BY LOCAL HEALTH OFFICER <b>6-2-83</b>	
35. PART I IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) (a) <b>Congestive heart failure</b>		Interval between onset and death <b>days</b>	
(b) DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death	
(c) DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death	
36. PART II OTHER SIGNIFICANT CONDITIONS—(Conditions contributing to death but not related to cause given in PART I (a)) <b>Diabetes Mellitus</b>		37. AUTOPSY (Specify Yes or No) <b>NO</b>	

THIS IS A PERMANENT RECORD  
 COMPLETE COPY OF THIS COUNTY HEALTH DEPT.  
 FILE WITH THE LAKE COUNTY HEALTH DEPT.  
 JUL 28 1983  
 JUL 3 1983

EMBALMER'S NAME... **SHERMAN G. BANKS**... LICENSE No. **141983**  
 FUNERAL DIRECTOR'S SIGNATURE...   
 FUNERAL HOME... **FUNERAL HOME**... No. **157**  
 AUDITOR LAKE COUNTY... **1625**  
 FUNERAL DIRECTOR'S LICENSE No. **1625**

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

PARENTS

DISPOSITION

CONDITIONS WHICH GAVE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE