

N 1/2 of following: W 1/2 of SW 1/4 (exc. S. 10 acres and except N. 30 acres thereof) 4c. 30 E.T. 7c. To 1/4

of Sec. 8, Twp. 35 N., Range 7 West of 2nd p. of Sec. 22 - 2-11. Key No.

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

Below for State Office Use

A. m.
B.
C.
D. 2nd p.
E.
F.
G.
H.
I.
J.
K.
L.
M.
N.
O.
P.
Q.
R.
S.
T.
U.
V.
W.
X.
Y.
Z.

Disposition Permit Issued / /
Provisional Certificate
 Yes No

CS 1183 58-84
792465

Local No. 1286-78

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TICOR TITLE INSURANCE
Crown Point, Indiana
Atty. Joanne Tapocsi
3 Lincolnway
State Valparaiso, IN 46183
No. 4128

FUNERAL HOME
No. 306

FUNERAL DIRECTOR'S
LICENSE No. 2012

604
60116 1978

EMBALMER'S NAME C. Scheuer

FUNERAL DIRECTOR'S SIGNATURE *Donald V. ...*

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION

PARENTS

DISPOSITION

M.D. OR D.O.

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

CAUSE

DECEASED—NAME 1. William D. Ford			SEX 2. Male	DATE OF DEATH (MONTH, DAY, YEAR) 3. October 7, 1978
RACE—(If White , Black, American Indian, etc.) (Specify) 4. White	AGE—Last Birthday (Yr) (M) (D) 5a. 87	UNDER 1 YEAR 5b. MOS	UNDER 1 DAY 5c. HOURS MINS	DATE OF BIRTH (Mo, Day, Yr) 6. 2-15-1891
CITY, TOWN OR LOCATION OF DEATH 7b. Hobart		HOSPITAL OR OTHER INSTITUTION—(Name (if not in other, give street and number)) 7c. St. Mary Medical Center		IF HOSP OR INST. Includes DOA, DP, Emer. Am., Inpatient (Specify) 7d. Inpatient
STATE OF BIRTH (If not in U.S.A. name country) 8. Pennsylvania	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. Married	SURVIVING SPOUSE (If wife, give maiden name) 11. Mabel Jones	
SOCIAL SECURITY NUMBER 13. 306-03-1411		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a. Speed Controler	KIND OF BUSINESS OR INDUSTRY 14b. Inland Steel Corp.	
RESIDENCE—STATE 15a. Indiana	COUNTY 15b. Lake	CITY, TOWN OR LOCATION 15c. Hobart		INSIDE CITY LIMITS (Specify YES OR NO) 15f. no
STREET AND NUMBER 15d. 6731 Grand Boulevard			IS RESIDENCE ON A FARM? 15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXXX	
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXXX				
FATHER—NAME FIRST MIDDLE LAST 16. John P. Ford (deceased)			MOTHER—MAIDEN NAME FIRST MIDDLE LAST 17. Lydia Cruse (deceased)	
INFORMANT—NAME (Type or print) 18a. Mabel Ford		MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE 18b. 6731 Grand Blvd., Hobart, IN 46342		
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b. Ridgelawn Cemetery		LOCATION CITY OR TOWN STATE 19c. Gary, Indiana
DATE (MONTH, DAY, YEAR) 20a. 10-9-1978		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE ZIP) 20b. Rees Funeral Home, Inc., 600 W. Ridge Rd., Hobart, IN 46342		
To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated 21a. (Signature) T.A. Gehring M.D.		DATE SIGNED (Mo., Day, Yr.) 21b. 10/11/78	HOUR OF DEATH 21c. 3:30 A.M.	
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d. T.A. Gehring, M.D.				
MAILING ADDRESS—PHYSICIAN 21e. 6111 Harrison, Merrillville, IN 46410				
HEALTH OFFICER'S SIGNATURE 22a. Rees Tracy M.D.		RECEIVED BY LOCAL HEALTH OFFICER 22b. FEB 15 1985		
23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a) AND (b)) PART (a) Probable recurrent cardiovascular accident		Interval between onset and death 1 hour		
(b) Generalized arteriosclerosis		Interval between onset and death		
(c)		Interval between onset and death		
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