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THIS DOCUMENT NOT VALID
UNLESS STAMPED ON REVERSE SIDE

EMBALMER'S NAME: *[Signature]* LICENSE NO. *1235*

FUNERAL HOME: *[Signature]* FUNERAL DIRECTOR'S LICENSE NO. *057*

File # 46-494-33
801488

Resub. in Miller Dunes Add.
W. 46 ft E. 1.33 BL. D
104 E VAC. Knox St Adj

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. _____

128

Local No. _____

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 FIRST MIDDLE LAST James Mace			SEX Male	DATE OF DEATH (MONTH DAY YEAR) April 15, 1985
RACE—(as White, Black, American Indian, etc.) Amer. Blk.	AGE—Last Birthday (Yr, Mos, Day) 48	UNDER 1 YEAR Mos Day	UNDER 1 DAY Hours Mins	DATE OF BIRTH (Mo, Day, Yr) Oct 9-36
CITY, TOWN OR LOCATION OF DEATH Valparaiso		HOSPITAL OR OTHER INSTITUTION—Name if not in other (give street and number) Porter Memorial Hospital		IF HOSP OR INST Indicate DOA OP Emer. Am. Institution (Specify) E.R.
STATE OF BIRTH (if not in U.S.A. name & country) PENNA.	CITIZEN OF WHAT COUNTRY U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	SURVIVING SPOUSE (if wife give maiden name) Hazel Mace	
SOCIAL SECURITY NUMBER 317-36-8853		USUAL OCCUPATION (give kind of work done, name of employer, and address if not in other) Bethlehem Steel	KIND OF BUSINESS OR INDUSTRY Steel	
RESIDENCE—STATE Indiana	COUNTY Lake	CITY, TOWN OR LOCATION Gary		
STREET AND NUMBER 6701 East 3rd Avenue			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
FATHER—NAME FIRST MIDDLE LAST Frank Mace		MOTHER—MAIDEN NAME FIRST Hazel Mace		
INFORMANT—NAME (Type or Print) RELATIONSHIP Hazel Mace (Wife)		MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 6701 East 3rd Avenue Gary Indiana 46603		
BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN STATE Greenwood Park Hobart Ind		
DATE (MONTH DAY, YEAR) 4-20-85		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Andrew Smith F.H. 934 E. 21ST. Avenue Gary Ind		
To the best of my knowledge, when occurred at the time, date and place and due to the cause(s) stated <i>[Signature]</i>		DATE SIGNED (Mo, Day, Yr) Apr 15, 1985	HOUR OF DEATH M	
NAME OF ATTENDING PHYSICIAN (Type or Print) Dr. R.R. Reed, M.D.		MAILING ADDRESS—PHYSICIAN 2450 169th Street Hammond, Indiana 46323		
HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		DATE RECEIVED BY LOCAL HEALTH OFFICER 4-16-85		
PART I IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) (a) ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF: (b) myocardial infarction DUE TO OR AS A CONSEQUENCE OF: (c) coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH MAY 2 1985 Auditor Lake County		
PART II OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in PART I (a))		AUTOPSY (Specify Yes or No)		

400

NO. 019884

PORTER HONNEY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Harry A. Balch, M.D.

HEALTH OFFICER



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