973340

Local No. 805-88

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. 7 REG 2 VET 9 TOTAL

Rees Funeral Home

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ARCHIE CUNNINGHAM
2. SEX: Male
3. DATE OF DEATH (Mo. Day, Yr.): April 12, 1988
4. SOCIAL SECURITY NUMBER: 306-09-1030
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): 1-16-1918
7. BIRTHPLACE (City and State or Foreign Country): SPRING BURN, SCOTLAND
8. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): ST. MARY'S MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): HELEN BAILEY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): TEAMSTER
12b. KIND OF BUSINESS/INDUSTRY: LOCAL 142
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 726 NORTH GUYER
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46342
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): WHITE
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): WILLIAM CUNNINGHAM (DECEASED)
18. MOTHER'S NAME (First, Middle, Maiden Surname): HANNAH JORDAN (DECEASED)

INFORMANT

19a. INFORMANT'S NAME (Type/Print): HELEN CUNNINGHAM
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 726 NORTH GUYER, HOBART, INDIANA 46342
19c. Relationship: SPOUSE

DISPOSITION

20a. METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 15, 1988 CALUMET PARK CEMETERY
20c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
21a. SIGNATURE OF FUNERAL DIRECTOR: Gerald V. Rees
21b. LICENSE NUMBER (of Licensee): FDE1041083
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME- FDH3003069 600 WEST OLD RIDGE RD., HOBART, IN 4634?

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <
23b. LICENSE NUMBER:
23c. DATE SIGNED (Month, Day, Year):

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 04:52P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): APRIL 12, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH — SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. CARDIO PULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
c. LEFT MAIN & TRIPLE VESSEL CORONARY ARTERY
DUE TO (OR AS A CONSEQUENCE OF):
d. DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not related to underlying cause given in Part I.

FILED

APR 19 1988

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

APR 19 1988 — CROWN POINT, INDIANA

CERTIFIER — SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] HEALTH OFFICER — 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) and manner as stated.

Oscar N. Oates — AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: Carlos, M.D.
29c. LICENSE NUMBER: 01026571
29d. DATE SIGNED (Month, Day, Year): 4-12-88
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): CRIS J. CARLOS MD, 8684 CONNECTICUT STREET, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): APR 13, 88

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

Margin notation: Rees Subdiv. 200 Lot 3 N. 30 ft. Bl. 4 Lot 6 Bl. 5 Lot 7 Bl. 5 Rev. 17-103-6

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD 1

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