

974803

551-88

INDIANA STATE BOARD OF HEALTH  
CERTIFICATE OF DEATH

*Non-Resident*

Local No. ....

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING  
PHYSICIAN ONLY

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

SEE INSTRUCTIONS

CAUSE OF  
DEATH

SEE  
INSTRUCTIONS

CERTIFIER

HEALTH  
OFFICER

CORONER OR  
MEDICAL  
EXAMINER USE  
ONLY

1 DECEASED—NAME FIRST MIDDLE LAST <b>Howard A. Dowell</b>					2 SEX <b>Male</b>	3 DATE OF DEATH (Mo. Day, Year) <b>March 12, 1988</b>
4 SOCIAL SECURITY NUMBER <b>306-09-8363</b>	5a AGE—Last Birthday (Years) <b>82</b>	5c UNDER 1 YEAR Months Days <b>0 0</b>	5e UNDER 1 DAY Hours Minutes <b>0 0</b>	6 DATE OF BIRTH (Month, Day, Year) <b>Mar. 13, 1905</b>	7 BIRTHPLACE (City and State or Foreign Country) <b>Welch, Okla.</b>	
8 YEAR LAST SERVED IN U.S. ARMED FORCES? <b>WWI U.S. Army</b>		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):				
9b FACILITY NAME (If not institution, give street and number) <b>St. Mary Medical Center</b>			9c CITY, TOWN OR LOCATION OF DEATH <b>Hobart</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS—Married Never Married Widowed. Divorced (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Blanche Hugo</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Electrician</b>		12b KIND OF BUSINESS/INDUSTRY <b>Sinclair Refinery</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>4054 Kentucky</b>		
13e INSIDE CITY LIMITS? (Yes or no) <b>Yes</b>	13f FARM <b>No</b>	13g ZIP CODE <b>46 401</b>	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>No</b>	15 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>	
17 FATHER'S NAME (First Middle Last) <b>Luciaus Grant</b>			18 MOTHER'S NAME (First Middle Maiden Surname) <b>Jennie Anderson</b>			
19a INFORMANT'S NAME (Type/Print) <b>Blanche Dowell</b>			19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4054 Kentucky Gary, Indiana 46401</b>		19c Relationship <b>Wife</b>	
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Evergreen Cemetery</b>		20c LOCATION—City or Town, State <b>Hobart, Indiana</b>		
21a SIGNATURE OF FUNERAL DIRECTOR <b>XX [Signature]</b>		21b LICENSE NUMBER (of Licensee) <b>FDH3007893</b>		22 HOME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Engel Funeral Home 2700 Willowcreek Portage, Ind.</b>		
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)		
24 TIME OF DEATH <b>6:05 A.M.</b>		25 DATE PRONOUNCED DEAD (Month, Day, Year) <b>March 12, 1988</b>		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) <b>Yes</b>		
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. <b>Intracranial hemorrhages; Congestion of lungs with</b> DUE TO (OR AS A CONSEQUENCE OF) <b>lobar consolidation. Due to beating</b> DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>Yes</b>				28b WERE AUTOPSY AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>Yes</b>		
29a 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. <input type="checkbox"/> 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. <input type="checkbox"/> MEDICAL EXAMINER <input checked="" type="checkbox"/> CORONER <input type="checkbox"/> 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.						
29b SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c LICENSE NUMBER <b>16120</b>		29d DATE SIGNED (Month, Day, Year) <b>March 15, 1988</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307</b>						
31 HEALTH OFFICER'S SIGNATURE <b>[Signature]</b>					32 DATE FILED (Month, Day, Year) <b>3-15-88</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) <b>Feb. 28, 1988</b>	34b TIME OF INJURY <b>No</b>	34c INJURY AT WORK? (Yes or no) <b>No</b>	34d DESCRIBE HOW INJURY OCCURRED <b>Beating</b>	
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <b>Home</b>				34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4054 Kentucky, Gary, IN.</b>		

FILED  
APR 27 1988  
CORONER - LAKE COUNTY, INDIANA  
CROWN POINT, INDIANA 46307  
JUDITH A. BLASTICK

Castro St 15 Bl 9 J. 23 KE 14 Bl 9 #42-278-15