992753

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1678-88

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Walter J. Decker
2. SEX: Male
3. DATE OF DEATH (Mo Day Yr): August 11,1988
4. SOCIAL SECURITY NUMBER: 316-24-6157
5a. AGE—Last Birthday (Years): 57
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): Apr.13,1931
7. BIRTHPLACE (City and State or Foreign Country): St.James,Missouri
8. YEAR LAST SERVED IN US ARMED FORCES? 1954
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): Community Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Patricia Pelfrey
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired
12b. KIND OF BUSINESS/INDUSTRY: L.T.V. Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Griffith
13d. STREET AND NUMBER: 1009 S.Park Avenue
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46319
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Walter J. Decker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Norma N/A

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Patricia Decker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 S.Park Ave., Griffith,IN 46319
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): August 15, 1988 Calumet Park Cemetery
20c. LOCATION—City or Town, State: Merrillville, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: C A Kuiper
21b. LICENSE NUMBER (of Licensee): FDE1014511
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home FDH300750, 9039 Kleinman Rd.,Highland,IN 46322

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: 5:15 P.M
25. DATE PRONOUNCED DEAD (Month, Day, Year): August 11, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Intracranial hemorrhages with Hematoma formation — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF)
b. Due to blunt force
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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 resulting in the underlying cause given in Part I

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
AUG 12 1988
LAKE COUNTY HEALTH COMMISSIONER

FILED FOR RECORD
AUG 17 1988
11 16 AM '88
LILLIAN A. BLASTICK
RECORDER LAKE COUNTY
CROWN POINT, INDIANA

FILED
AUG 17 1988
AUDITOR LAKE COUNTY

CERTIFIER

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 [X] 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

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel D. Thomas M.D.
29c. LICENSE NUMBER: 16120
29d. DATE SIGNED (Month, Day, Year): August 11, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [illegible signature]
32. DATE FILED (Month, Day, Year): August 12, 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: [ ] Natural [X] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
34a. DATE OF INJURY (Month, Day, Year): Aug.10,1988
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no): No
34d. DESCRIBE HOW INJURY OCCURRED: Fell down stairs
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Home
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1009 S. Park, Griffith, Indiana

4.00

SBH06-004 State Form 10110 Rev. 10/87 DEATH,PD I

Griffith Highschool 1st Add. to Griffith L.12 #26-229-12