INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 727 996325

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
AUG 3 0 1988 Date Issued — Franklin 9. [illegible] M.D. Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: FIRST James MIDDLE B. LAST Poindexter
2. SEX: Male
3. DATE OF DEATH (Mo. Day, Yr.): August 26, 1988
4. SOCIAL SECURITY NUMBER: 431-42-2562
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): Feb. 4, 1923
7. BIRTHPLACE (City and State or Foreign Country): Vanndale, Arkansas
8. YEAR LAST SERVED IN US ARMED FORCES?: No
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Betty Maksimik
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Paint Mixer
12b. KIND OF BUSINESS/INDUSTRY: Paint Company
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 4846 Columbia Avenue
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46327
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ 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+):

KEY 36-142-26 STAFFORD & TRANS [illegible] IRON WORKERS 400 N 2 L 1 8 ALL 6 ? + 526.80

PARENTS

17. FATHER'S NAME (First, Middle, Last): Clayton Poindexter
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eulah Miller

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Betty Poindexter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4846 Columbia Avenue, Hammond, IN 46327
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 30, 1988 Vanndale Cemetery
20c. LOCATION—City or Town, State: Vanndale, Arkansas
21a. SIGNATURE OF FUNERAL DIRECTOR: Keith D. Anthony
21b. LICENSE NUMBER (of Licensee): 1011911
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Anthony & Dziadowicz F.H.- 3002835 4404 Cameron Ave., Hammond, IN 46327

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: [signature] M.D.
23b. LICENSE NUMBER: 3525
23c. DATE SIGNED (Month, Day, Year): Aug 26 1988

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

24. TIME OF DEATH: 4:45 P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): Aug 26 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. ACUTE CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF)
b. SHOCK
DUE TO (OR AS A CONSEQUENCE OF)
c. ACUTE BLOOD LOSS
DUE TO (OR AS A CONSEQUENCE OF)
d. ACUTE RUPTURE OF ABDOMINAL AORTIC ANEURYSM

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.
HYPERTENSIVE CARDIOVASCULAR DISEASE, OBSTRUCTIVE PULMONARY DISEASE, PEPTIC ULCER DISEASE

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

SEP 8 12 52 PM '88
LILLIAN A. BLASTICK RECORDER, LAKE COUNTY
FILED FOR RECORD
FILED

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.

SEP 8 1988
[signature] Anton
AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: Evan H. Geissler, D.O.
29c. LICENSE NUMBER: 568
29d. DATE SIGNED (Month, Day, Year): August 29, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): E. H. Geissler, D.O. 13101 Baltimore, Chicago, Illinois 60633

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin 9. [illegible] M.D.
32. DATE FILED (Month, Day, Year): AUG 3 0 1988

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)

400
435

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