12 + 2

Local No. 66 90 082710

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	Oscar L. Wright
2. SEX	Male
3a. TIME OF DEATH	9:20A M
3b. DATE OF DEATH (Month, Day, Yr)	January 9, 1990
4. SOCIAL SECURITY NUMBER	401-28-7394
5a. AGE—Last Birthday (Years)	70
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	JAN 30, 1919
7. BIRTHPLACE (City and State or Foreign Country)	Horton, KY
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1945
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)	Our Lady of Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	Dyer
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Marguerite Black
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Operating Engineer
12b. KIND OF BUSINESS/INDUSTRY	Standard Oil
13a. RESIDENCE—STATE	Indiana,
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Crown Point
13d. STREET AND NUMBER	9450 Cleveland St.
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Henry Wright
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Pearl Bryant

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Marguerite Wright
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	9450 Cleveland St., Crown Point, IN 46307
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☒ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Minter-Schapmire F.H.; JAN 13, 1990; Old Bethel Cemetery
21c. LOCATION—City or Town, State	Hartford, KY; Beaver Dam, KY
22a. EMBALMER'S NAME	Marty Andersen
22b. EMBALMER'S LICENSE NO.	FD01005205
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FD01000328
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Geisen Funeral Home, Inc. - FD83001253, 109 N East St, Crown Point, IN46307

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, 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): Acute Arrythmia

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE WITH THE LAKE CO. HEALTH DEPT.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: CVA

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)

28a. WAS AN AUTOPSY PERFORMED? No

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one)
- ☒ CERTIFYING PHYSICIAN - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
- ☐ 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) as stated.
- ☐ CORONER - 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01055397
29d. DATE SIGNED (Month, Day, Year)	10 Jan 90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Ray J. Zimmerman M.D., 1326 US Rt. 30, Schererville, IN 46375

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month, Day, Year)	Jan. 10, 1990

CORONER USE ONLY

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

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4.00

FILED JAN 31 1990

#23-102-16 Fountain Ridge #1 Rt 16 + S. 3' Rt 15

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