084114

TYPE OR PRINT PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

Below for State Office Use

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

Local No. 310-78

State No. 139

TYPE OR PRINT PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

1 DECEASED—NAME (First, Middle, Last): JOHN E. CHRISTIAN

2 SEX: Male

3 DATE OF DEATH (Month, Day, Year): March 7, 1978

4 RACE (e.g. White, Black, American Indian, etc.): White

5a AGE (Last Birthday): 44

5b UNDER 1 YEAR — MOS. / DAYS

5c UNDER 1 DAY — HOURS / MINS.

6 DATE OF BIRTH (Mo., Day, Yr.): 3-17-1933

7a COUNTY OF DEATH: Lake

7b CITY, TOWN OR LOCATION OF DEATH: Hobart

7c HOSPITAL OR OTHER INSTITUTION: St. Mary Medical Center

7d IF HOSP. OR INST. indicate DOA or Emer. Rm. Inpatient (Specify): Inpatient

8 STATE OF BIRTH (If not in U.S.A. name country): Indiana

9 CITIZEN OF WHAT COUNTRY: U.S.A.

10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Doris Richeson

12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No): Yes

13 SOCIAL SECURITY NUMBER: 315-28-7318

14a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Disabled

14b KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (Where deceased lived. If death occurred in institution, give residence before admission)

15a RESIDENCE—STATE: Indiana

15b COUNTY: Lake

15c CITY, TOWN OR LOCATION: Hobart

15d STREET AND NUMBER: 411 W. Ridge Rd.

15e IS RESIDENCE ON A FARM? YES ☐ NO ☒

15f INSIDE CITY LIMITS? (Specify Yes or No): Yes

16 IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES ☐ NO ☒

PARENTS

17 FATHER—NAME (First, Middle, Last): Sam Christian (deceased)

18 MOTHER—MAIDEN NAME (First, Middle, Last): Mary Taus (deceased)

19 INFORMANT—NAME (Type or print): Doris Christian

19a MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip): 411 W. Ridge Rd., Hobart, Indiana 46342

DISPOSITION

20a BURIAL, CREMATION, REMOVAL, OTHER (Specify): Burial

20b CEMETERY OR CREMATORY—FUNERAL HOME: Calvary Cemetery

20c LOCATION (City or Town, State): Portage, Indiana

20d DATE (Month, Day, Year): March 10, 1978

20e FUNERAL HOME—NAME AND ADDRESS (Street or R.F.D. No., City or Town, State, Zip): Rees Funeral Home, Inc., 600 W. Ridge Rd., Hobart, IN 46342

M.D. OR D.O.

21a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature): Philip E. Kellar M.D.

21b DATE SIGNED (Mo., Day, Yr.): March 8, 1978

21c HOUR OF DEATH: 6:00 AM

21d NAME OF ATTENDING PHYSICIAN (Type or Print): Philip E. Kellar M.D.

21e MAILING ADDRESS—PHYSICIAN: 904 W. Ridge Rd., Hobart, Indiana 46342

22a HEALTH OFFICER—SIGNATURE: Rees Funeral Home M.D.

22b DATE RECEIVED BY LOCAL HEALTH OFFICER: 3-10-78

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

23 PART I — IMMEDIATE CAUSE (Enter only one cause per line for a, b, and c.)

(a) Acute Myocardial Infarction — Interval between onset and death: 1 min

DUE TO OR AS A CONSEQUENCE OF

(b) Congestive Heart Failure — Interval between onset and death: years

DUE TO OR AS A CONSEQUENCE OF

(c) Arteriosclerotic Heart Disease — Interval between onset and death: years

PART II — OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I(a): Cryoglobulinemia; Renal Failure; Pneumonia — Autopsy (Specify Yes or No): Yes

SBH 06-003
REV. 10/77

EMBALMER'S NAME: J. Krause

LICENSE No.

FUNERAL DIRECTOR'S SIGNATURE: Rees Funeral Home

FUNERAL DIRECTOR'S LICENSE No.

FUNERAL No. 2012

FILED

Disposition Permit Issued / /

Provisional Certificate ☐ Yes ☐ No

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