[illegible] No. 092829

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. 46406

Rev. Larry Coaly
4709 W 5th Ave
Gary 46406

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo Day Yr)
Jessie		Mukes	Male	May 30, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
436-24-3964	69			12/24/1919	Louisiana

8 WAS DECEASED EVER IN US ARMED FORCES?

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)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital Northlake	Gary	Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Gladys Mathis	Truck Driver	LTV Steel Corp

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
IN	Lake	Gary	4315 W. 10th AVe

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican etc.)	15 RACE—American Indian, Black, White etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
yes	no		☒ No ☐ Yes	Black	

PARENTS

17 FATHER'S NAME (First Middle Last)	18 MOTHER'S NAME (First Middle Maiden Surname)
James Mukes	Olivia Wright

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
Glayds Mukes	4315 W. 10th Ave	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)	20c LOCATION—City or Town, State
6/4/1988 Evergreen Cemetery	Hobart, Indiana

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1051701	Guy & Allen Funeral Directors, IN[C] 2959 W. 11thAve 3007704

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)

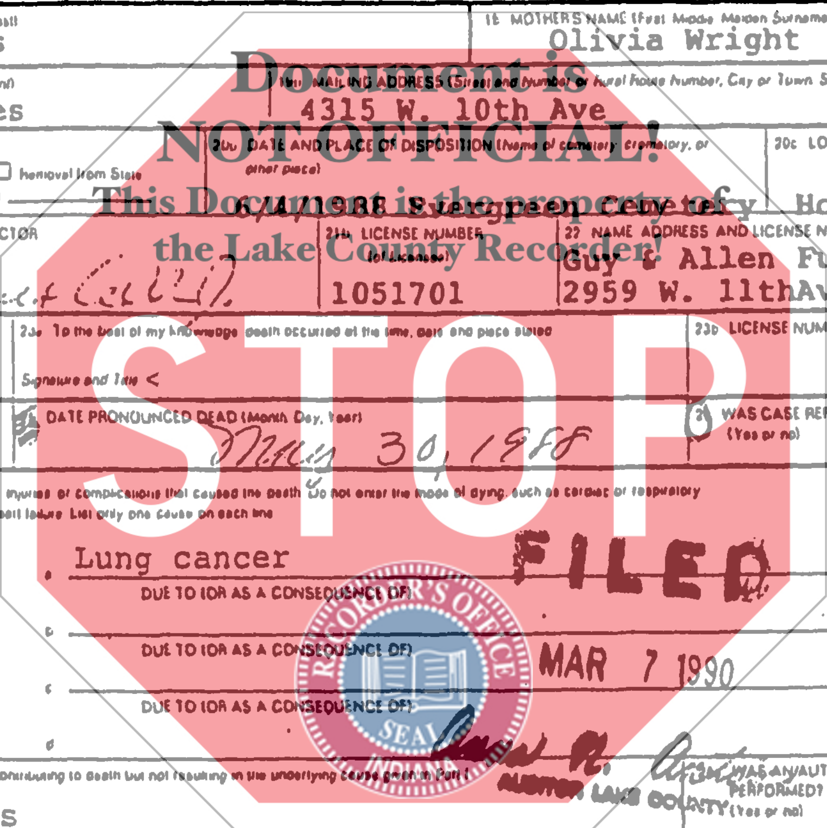
ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month Day Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
2:14 Am	May 30, 1988	No

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Lung cancer	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. 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)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Hemoptysis	No	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STOP

FILED MAR 7 1990
AUDITOR LAKE COUNTY

ROBERT [illegible] RECORDER
APR 27 [illegible] 90
FILED [illegible] COUNTY
STATE OF [illegible] S.S. NO.

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 ☐ 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	29c LICENSE NUMBER	29d DATE SIGNED (Month Day Year)
[signature]	01027321	6/1/88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

Sampanta Boonjarern, M.D., 8969 Broadway, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
James T. Hedrick [signature]	JUN 15 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)

000313

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