1 C C

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 90-0145 093061

State No. Gary 46401

Calvin Hawkins Bk M 859

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
Rev. Stanley A. Terry	Male	5:41 PM	February 25, 1990

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 (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
384-40-3061	54			Oct. 28, 1935	Detroit, Michigan

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
N/A	N/A	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
556 Mc Kinley St.	Gary	Lake

10. MARITAL STATUS (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	Adele Taylor	Personnel Director	City

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	556 Mc Kinley St.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46404	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White		5+

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Stanley E. Terry	Anne Unavailable

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Mark Terry	544 Roosevelt St. Gary, Indiana 46404	Son

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☒ Donation ☐ Other (Specify)	February 26, 1990 Demonstrators Anatomical Gifts	Chicago, IL.

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
N/A	N/A	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FDO 1014511	Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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) a.	Vascular collapse	Unknown
b. DUE TO (OR AS A CONSEQUENCE OF)	Due to arteriosclerotic heart & vascular disease	
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	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

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	16120	Feb. 26, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	FEB. 27 1990

CORONER 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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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.

000181 40C

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

#44-170-92 Ce 12 Oct 16
Gary Rd. Cir. 4th Div.

FILED APR 03 1990 [signature] RECORDER LAKE COUNTY

STATE OF INDIANA S.S. NO. LAKE COUNTY FILED FOR RECORD APR 3 28 PM '90 ROBERT "BOB" FREELAND RECORDER

RECORDER'S OFFICE SEAL INDIANA

CERTIFIED BY:

Thelma E Fosterson M.D.

HEALTH COMMISSIONER
CITY OF GARY, IND.

MAY 6 1940

DATE_____