PATRICIA EVANS P.O. Box 3547, East Chgo, 463 12

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 093924 63 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Lawrence D. Evans
2. SEX: Male
3a. TIME OF DEATH: 11:17 A.M.
3b. DATE OF DEATH (Month, Day, Yr.): March 12, 1990
4. SOCIAL SECURITY NUMBER: 305-52-0228
5a. AGE—Last Birthday (Years): 44
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): Jan. 18, 1946
7. BIRTHPLACE (City and State or Foreign Country): East Chicago
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
8c. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☒ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
8d. FACILITY NAME (If not institution, give street and number): 3826 Deal Street
8e. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
8f. COUNTY OF DEATH: Lake
9. MARITAL STATUS (Specify): Married
10. SURVIVING SPOUSE (If wife, give maiden name): Patricia
11a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SUPERVISOR
11b. KIND OF BUSINESS/INDUSTRY: CITY OF E. CHICAGO
12a. RESIDENCE—STATE: Indiana
12b. COUNTY: Lake
12c. CITY, TOWN OR LOCATION: East Chicago
12d. STREET AND NUMBER: 3826 Deal Street
12e. ZIP CODE: 46312
12f. INSIDE CITY LIMITS? ☐ No ☒ Yes
12g. ON A FARM? ☒ No ☐ Yes
13. CITIZEN OF WHAT COUNTRY? U.S.A.
14. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
15. RACE—American Indian, Black, White, etc. (Specify): Black
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): TONY MIELSOP
18. MOTHER'S NAME (First, Middle, Maiden Surname): LUCILLE EVANS

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Patricia Evans
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3826 Deal Street, East Chicago, IN 46312
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 16, 1990 Oak Hill Cemetery, Gary, Ind.
20c. LOCATION—City or Town, State: Gary, Indiana
21a. EMBALMER'S NAME: ROSENWALD D. ALLEN
21b. EMBALMER'S LICENSE NO: #1010606
22. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
23a. SIGNATURE OF FUNERAL DIRECTOR: Rosenwald D. Allen
23b. LICENSE NUMBER (of Licensee): #1010606
23c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Allen Funeral Home FDH#3007966, 3546 Guthrie, E.Chicago, IN 46312

CAUSE OF DEATH

24. 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.
Immediate cause (Final disease or condition resulting in death): a. Vascular collapse
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. Due to arteriosclerotic & hypertensive coronary; c. heart disease. History of dinbetes.
d.
Approximate Interval Between Onset and Death: Unknown
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I:
25. WAS DECEDENT PREGNANT IN PAST YEAR? No
26. WAS AN AUTOPSY PERFORMED? (Yes or no) No
27. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

28a. CERTIFIER (Check only one): ☐ To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ 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. ☐ 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.
28b. SIGNATURE AND TITLE OF CERTIFIER: [redacted]
29c. MEDICAL LICENSE NO: 16120
29d. DATE SIGNED (Month, Day, Year): Mar. 14, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 28) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: E. A. Campagnoni
32. DATE FILED (Month, Day, Year): 3-19-90

CORONER 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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 430

SBH06-804 State Form 10110 (R8/3-89) DEA CERT/PD 1

#30-342-92 Indiana Vital Records 10

4.00