

INDIANA STATE BOARD OF HEALTH

4580 Buchanan St
Gary 46408
State No.

Local No. 415-90 094255

CERTIFICATE OF DEATH

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

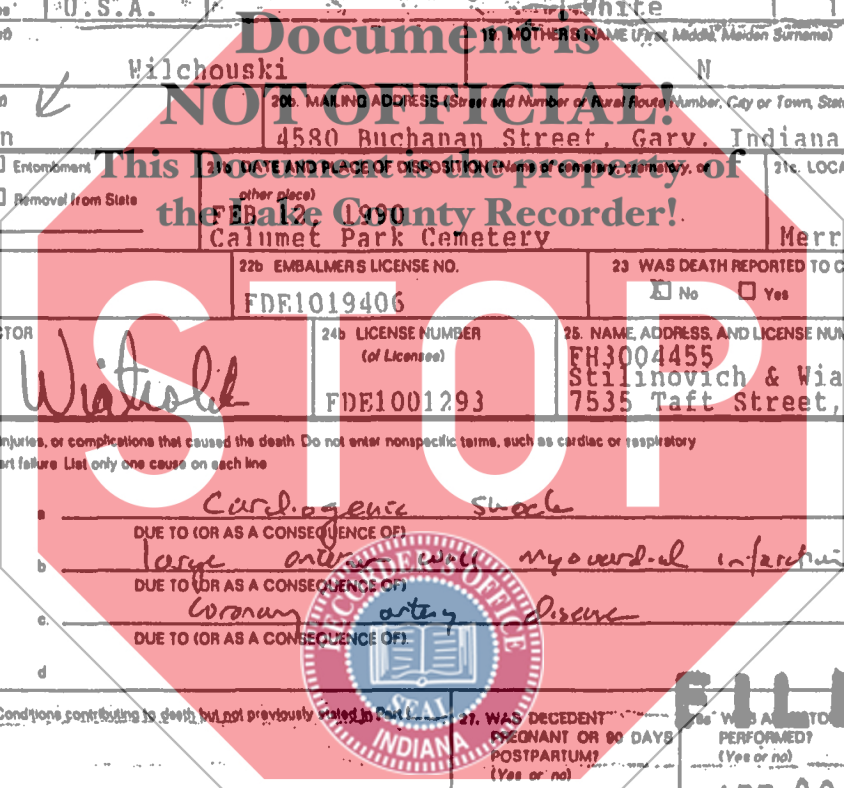
CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) Joseph A. Wilden Hale				2. SEX Male		3a. TIME OF DEATH 10:48P M		3b. DATE OF DEATH (Month, Day, Yr) February 7, 1990	
4. SOCIAL SECURITY NUMBER 306-09-6423		5a. AGE—Last Birthday (Years) 75		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) DEC 12, 1914	
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana		8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN US ARMED FORCES?		8c. PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake				9b. CITY, TOWN, OR LOCATION OF DEATH Merrillville			9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Marvabelle Brown		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steel Worker			12b. KIND OF BUSINESS/INDUSTRY U.S. Steel		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 4580 Buchanan Street			
13e. ZIP CODE 46408		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (HS) 12 College (1-4 or 5) OBSTETRICIAN Professional PR 9		18. FATHER'S NAME (First, Middle, Last) Joseph Wilchouski		19. MOTHER'S NAME (First, Middle, Last) N		20a. INFORMANT'S NAME (Type/Print) Marvabelle Wilden		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4580 Buchanan Street, Gary, Indiana 46408	
20c. Relationship Wife		21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, or other place) Feb 12, 1990 Calumet Park Cemetery			21c. LOCATION—City, Town, State Merrillville, Indiana 46410		
22a. EMBALMERS NAME Henry Blake		22b. EMBALMER'S LICENSE NO. FDE1019406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		24a. SIGNATURE OF FUNERAL DIRECTOR Robert Wiatrolik		24b. LICENSE NUMBER (of Licensee) FDE1001293	
24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH3004455 Stillinovich & Wiatrolik Funeral Home 7535 Taft Street, Merrillville, IN 46410		25. 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. a. Cardiogenic shock b. large anterior wall myocardial infarction c. coronary artery disease		Approximate Interval Between Onset and Death Days Days years		26. 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)	
27a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		27d. DATE FILED (Month, Day, Year) APR 09 1990		27e. SIGNATURE OF HEALTH OFFICER Charles J. Pharo	
28a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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) as stated		28b. SIGNATURE AND TITLE OF CERTIFIER Charles J. Pharo		28c. MEDICAL LICENSE NO. 031712		28d. DATE SIGNED (Month, Day, Year) 2-13-90		28e. SIGNATURE OF HEALTH OFFICER Charles J. Pharo	
29. SIGNATURE AND TITLE OF HEALTH OFFICER Charles J. Pharo		30. SIGNATURE AND TITLE OF CORONER Charles J. Pharo		31. SIGNATURE AND TITLE OF HEALTH OFFICER Charles J. Pharo		32. DATE FILED (Month, Day, Year) Feb. 13, 1990		33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Other (Specify) FEB 13 1990	
34a. DATE OF INJURY (Month, Day, Year) FEB 13 1990		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) 40		34g. DATE PRONOUNCED DEAD (Month, Day, Year) LAKE COUNTY HEALTH COMMISSIONER		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		34i. MOTOR VEHICLE IDENTIFICATION NO. 000509	

Key # 47-48-22 L.B. Pharo's Card should be filed to Gary, Feb 22, 1990



STATE OF INDIANA
LAKE COUNTY
FILED
FEB 9 1990
MERRILLVILLE, IN 46410