INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 54005123 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1 DECEASED—NAME (First, Middle, Last)	Scott P. Webber
2 SEX	Male
3a TIME OF DEATH	7:01 PM
3b DATE OF DEATH (Month Day Yr)	February 27, 1990
4 SOCIAL SECURITY NUMBER	309-24-9980
5a AGE—Last Birthday (Years)	60
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	JUL 5, 1929
7 BIRTHPLACE (City and State or Foreign Country)	Lombard, Illinois
8a WAS DECEDENT A US VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number)	St. Catherine Hospital
9c CITY, TOWN OR LOCATION OF DEATH	East Chicago
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Mary Ann Betterton
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	General Forman
12b KIND OF BUSINESS/INDUSTRY	Inland Steel
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	6646 Montana Avenue
13e ZIP CODE	46323
13f INSIDE CITY LIMITS?	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5+)	

PARENTS

Field	Value
18 FATHER'S NAME (First, Middle, Last)	Ralph Webber
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Dorothy Johnson

INFORMANT

Field	Value
20a INFORMANT'S NAME (Type/Print)	Mary Ann Webber
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	6646 Montana Avenue, Hammond, Indiana 46323
20c Relationship	Wife

DISPOSITION

Field	Value
21a METHOD OF DISPOSITION	☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March 2, 1990 Chapel Lawn Memorial Gardens
21c LOCATION—City or Town, State	Schererville, Indiana
22a EMBALMER'S NAME	Charles D. Scheuer Jr.
22b EMBALMER'S LICENSE NO	1006049
23 WAS DEATH REPORTED TO CORONER?	☐ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	John V. Huber [signature]
24b LICENSE NUMBER (of Licensee)	1045362
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	minutes
DUE TO (OR AS A CONSEQUENCE OF) b.	Coronary Artery Disease	
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

FILED APR 11 1990

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Throat Cancer

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)

28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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

Field	Value
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	02000686
29d DATE SIGNED (Month, Day, Year)	3/1/90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Steven A. Corse D.O., 1573 North Cline Avenue, Griffith, Indiana 46319

HEALTH OFFICER

Field	Value
31 HEALTH OFFICER'S SIGNATURE	E. A. Campagna, MD
32 DATE FILED (Month, Day, Year)	3-2-90

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

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4.00 ch

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

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