INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

095906

Local No. 1831-90 State No. ....

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)
STANLEY J. MUNSON	MALE	1:00 PM	APRIL 8, 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)
481-22-3400	82			JULY 7, 1907	INDIANAPOLIS, INDIANA

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO		HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
COMMUNITY HOSPITAL	MUNSTER	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	KATHERINE KEITH	PHOTO ENGRAVER	PRINTING CO.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	MUNSTER	9843 WHITE OAK

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+)
46321	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	WHITE	12 YRS /

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
PEDRO MUNSON	GRACE HALVERSON

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
KATHERINE MUNSON	9843 WHITE OAK, MUNSTER, IND. 46321	WIFE

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State	APRIL 12, 1990 CALUMET PARK CEMETERY	MERRILLIVILLE, IND.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
THOMAS J. BURNS	1045184	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Thomas J. Burns	1045184	BURNS-KISH FUNERAL HOME #3004968 8415 CALUMET AVENUE AND MUNSTER, IND. 46321

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. Cardiac Arrest

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

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)

FILED APR 19 1990

Anna R. Anton
AUDITOR LAKE COUNTY

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)
RSBhagwat	01035958	4-12-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
DR. BHAGWAT, 5500 HOHMAN AVE, HAMMOND, IND 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day, Year)
[signature]	APR 14, 90

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
	4.00

Key #28-14-19 PT NW NW S.32 T.36 R.9 5AC "165 73X 1314 . 32X115 . 73X 132"

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

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