Local No. 487-90096258

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

K J Boozie
7724 Mulinex Ct
Lynwood Ill 60411

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Gale H. Lloyd, Sr.
2. SEX: Male
3a. TIME OF DEATH: 2:57 A.
3b. DATE OF DEATH (Month, Day, Yr): February 22, 1990
4. SOCIAL SECURITY NUMBER: 337-03-7467
5a. AGE—Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Nov. 15, 1904
7. BIRTHPLACE (City and State or Foreign Country): Mc Cool, IN.
8a. WAS DECEDENT A U.S. VETERAN?: N/A
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): The Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Emily Hull
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Repairman
12b. KIND OF BUSINESS/INDUSTRY: Accounting Machine
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 1105 170th Pl.
13e. ZIP CODE: 46320
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Wilbur J. Lloyd
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lanah Fifield

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Emily Lloyd
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1105 170th Pl. Hammond, Indiana
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 24, 1990 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO.: FDO 1016173
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: A Kuiper
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 380-7500

STATE OF INDIANA/S.S. NO.

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. Lt ~~[illegible]~~ Intertrochanteric [illegible] reduced
DUE TO (OR AS A CONSEQUENCE OF):
b. acute [illegible]
DUE TO (OR AS A CONSEQUENCE OF):
c. ileus.
DUE TO (OR AS A CONSEQUENCE OF):
d. ~~Kidney f~~ acute renal failure

Conditions, if any, which gave rise to 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): NO
28a. WAS AN AUTOPSY PERFORMED?: NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THIS CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FEB 23 1990

LAKE COUNTY HEALTH COMMISSIONER

FILED
APR 19 1990
Anna N. Anton
AUDITOR LAKE COUNTY

CERTIFIER

29a. (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: 032690
29d. DATE SIGNED (Month, Day, Year): 2-23-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SAMI AHMADZAI M.D. 6933 Kennedy HAMMOND IN 46323

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Basil Johnson MD
32. DATE FILED (Month, Day, Year): FEB 23 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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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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