3cc 096771
89-0684

Local No. ....

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

J. Laurence Anderson
1109 Bradway
State No. Gary, I.G. 407.....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Arthur Amison
2 SEX	male
3a TIME OF DEATH	0:600A
3b DATE OF DEATH (Month Day Yr)	October 14,1989
4 SOCIAL SECURITY NUMBER	312-05-0788 A
5a AGE—Last Birthday (Years)	82
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	Oct. 11, 1907
7 BIRTHPLACE (City and State or Foreign Country)	Utah, Alabama
8a WAS DECEDENT A US VETERAN?	no
8b YEAR LAST SERVED IN US ARMED FORCES?	never
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XXXX Residence
9b FACILITY NAME (If not institution, give street and number)	1425 Georgia Street
9c CITY, TOWN OR LOCATION OF DEATH	Gary
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	married
11 SURVIVING SPOUSE (If wife, give maiden name)	Louise Jane Tubbs
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	steelworker
12b KIND OF BUSINESS/INDUSTRY	USX Steel Co.
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	1425 Georgia Street
13e ZIP CODE	46407
13f INSIDE CITY LIMITS	☐ No XXX Yes
13g ON A FARM?	XXX ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc)	XXXX ☐ Yes
16 RACE—American Indian, Black, White, etc (Specify)	Afro Amer
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	06
College (1-4 or 5+)	

PARENTS

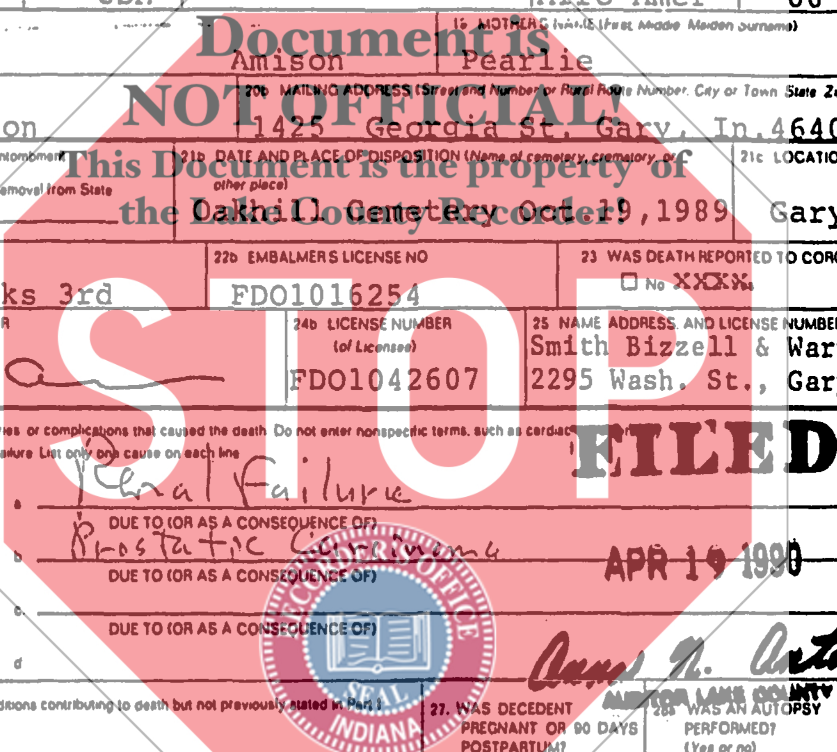
Field	Entry
18 FATHER'S NAME (First Middle Last)	Tom Amison
19 MOTHER'S NAME (First Middle Maiden Surname)	Pearlie Cox

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Louise J. Amison
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1425 Georgia St. Gary, In.46407
20c Relationship	wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	XXXXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Oakhill Cemetery Oct.19,1989
21c LOCATION—City or Town State	Gary, Indiana
22a EMBALMER'S NAME	Sherman G. Banks 3rd
22b EMBALMER'S LICENSE NO	FDO1016254
23 WAS DEATH REPORTED TO CORONER?	☐ No XXXX
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	FDO1042607
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Smith Bizzell & Warner, Inc. FDH3002487 2295 Wash. St., Gary,Indiana 46407



CAUSE OF DEATH

26. PART I Enter the diseases, injuries or complications that caused the death. Do not enter nonspecific terms, such as cardiac 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	Renal Failure	3 weeks
DUE TO (OR AS A CONSEQUENCE OF) b	Prostatic Carcinoma	18 months
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 19 1990
Anna M. Anton
AUDITOR LAKE COUNTY

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hepatoma. Diabetes Mellitus CHF

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)
no	no	no

CERTIFIER

29a CERTIFIER (Check only one)
XXX 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)
[signature] MD	01033117	10/16/89

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Bayne W. Spottwood 636 East 21st Ave. Gary, In. 46407

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
[signature] MD	OCT. 1 9 1989

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

000353

4.00 Ck

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

9th Sub. L.C. Bl 8 - L 7 - Bl 8
Key # 44-266-5 Dairy Land Add.

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 19 1990

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE OCT. 19 1989