KEY 49-456-4, 5 & 6
MIDWAY GARDENS 2nd ADD
LOTS 4, 5, 6 & 7 BLOCK 4

al No. 90 0304

096939

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	Stuarte M. Cable
2. SEX	Male
3a. TIME OF DEATH	3:41 P.
3b. DATE OF DEATH (Month Day Yr)	April 19, 1990
4. SOCIAL SECURITY NUMBER	396-07-8811
5a. AGE—Last Birthday (Years)	84
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	Jul, 15, 1905
7. BIRTHPLACE (City and State or Foreign Country)	Elpaso, Illinois
8a. WAS DECEDENT US VETERAN?	Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?	WW-II
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)	Methodist Hospital Northlake Campus
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)	Ruth Williamson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Iron Worker
12b. KIND OF BUSINESS/INDUSTRY	Union
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Gary
13d. STREET AND NUMBER	2333 Durbon
13e. ZIP CODE	46406
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? (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) / College (1-4 or 5+)	6

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	George Cable
19. MOTHER'S NAME (First Middle Maiden Surname)	Mary Kridner

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Ruby Cable
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2333 Durbin Gary, Indiana 46406
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	April 23, 1990 Chapel Lawn Cemetery
21c. LOCATION—City or Town State	Schererville, IN
22a. EMBALMER'S NAME	Ronald A. Reed
22b. EMBALMER'S LICENSE NO	FDO 1001081
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 300-7500

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	Instant
DUE TO (OR AS A CONSEQUENCE OF) b.	Conduction defect Rt Bundle Branch Block	3 yrs
DUE TO (OR AS A CONSEQUENCE OF) c.	Left Anterior Hemiblock	
DUE TO (OR AS A CONSEQUENCE OF) d.	Arteriosclerosis with Ischemia	

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

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Gout Arthritis

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)
☒ 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)
W.A. Nelson MD	12648	4-20-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W.A Nelson MD 559 So Lake St Gary In. 46403

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Belva E Foster MD MPH 120

32 DATE FILED (Month, Day, Year): FILED APR. 20 1990

CORONER 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 ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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

APR 21 1990
Anna N. Anton
AUDITOR LAKE COUNTY

4.00

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD '90 APR 24 ... 2 ...

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

979

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE APR. 20 1990