TYPE OR PRINT PLAINLY, WITH UNFADABLE INK. THIS IS A PERMANENT RECORD

Below for State Office Use

089250

Local No. 158-85

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. 03537

FUNERAL HOME No. 427

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

PARENTS

DISPOSITION

M.D. OR D.O.

CAUSE

1. DECEASED—NAME (First, Middle, Last)	ELVIN E. GRAVES
2. SEX	Male
3. DATE OF DEATH (Month Day Year)	June 11, 1985
4. RACE	White
5a. AGE (Last Birthday)	67
5b. UNDER 1 YEAR — MOS. / DAYS	
5c. UNDER 1 DAY — HOURS / MINS.	
6. DATE OF BIRTH (Mo. Day Yr.)	9-22-1917
7a. COUNTY OF DEATH	Lake
7b. CITY, TOWN OR LOCATION OF DEATH	Crown Point
7c. HOSPITAL OR OTHER INSTITUTION (Name if not in hospital give street and number)	St. Anthony Medical Center
7d. IF HOSP. OR INST. (Enter DOA if dead on arrival) (Specify Yes or No)	Inpatient
8. STATE OF BIRTH (If not in U.S.A. name country)	Indiana
9. CITIZEN OF WHAT COUNTRY	U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	Married
11. SURVIVING SPOUSE (If wife give maiden name)	Luella Krumm
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)	No
13. SOCIAL SECURITY NUMBER	311-03-1601
14a. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Retired
14b. KIND OF BUSINESS OR INDUSTRY	Graves Welding Shop
15a. RESIDENCE—STATE	Indiana
15b. COUNTY	Lake
15c. CITY, TOWN OR LOCATION	Lowell
15d. STREET AND NUMBER	19907 Drummond
15e. IS RESIDENCE ON A FARM?	YES ☐ NO ☒
15f. INSIDE CITY LIMITS (Specify YES or NO)	No
15g. IS DECEASED OF SPANISH DESCENT? (If YES specify MEXICAN, CUBAN, PUERTO RICAN, ETC.)	YES ☐ NO ☒
16. FATHER—NAME (First, Middle, Last)	Henry Graves
17. MOTHER—MAIDEN NAME (First, Middle, Last)	Grace Storie
18a. INFORMANT—NAME (Type or print)	Mrs. Luella Graves, Wife
18b. RELATIONSHIP	
18c. MAILING ADDRESS (Street or R.D. No.)	19907 Drummond
18d. CITY OR TOWN, STATE, ZIP	Lowell, Indiana 46356
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	Burial
19b. CEMETERY OR CREMATORY—FUNERAL HOME	Sanders Cemetery
19c. LOCATION: CITY OR TOWN, STATE	Lowell, Indiana
20a. DATE (Month Day Year)	6-14-85
20b. FUNERAL HOME—NAME AND ADDRESS (Street or R.D. No. City or Town State ZIP)	Sheets-Love Funeral Home 604 E. Commercial Ave. Lowell, In 46356
21a. To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. (Signature)	
21b. DATE SIGNED (Mo. Day Yr.)	6-12-85
21c. HOUR OF DEATH	
21d. NAME OF ATTENDING PHYSICIAN (Type or Print)	Jerold N. Chip, M.D.
21e. MAILING ADDRESS—PHYSICIAN (Street or R.D. No. City or Town State ZIP)	7863 Broadway Merrillville, Indiana 46410
22a. HEALTH OFFICER—SIGNATURE	
22b. DATE RECEIVED BY LOCAL HEALTH OFFICER	6-17-85
23. PART I. IMMEDIATE CAUSE (Enter ONLY ONE CAUSE PER LINE) (a)	Cardiac Arrhythmia
DUE TO OR AS A CONSEQUENCE OF (b)	Myocardial Infarction
DUE TO OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I	
24. AUTOPSY (Specify Yes or No)	

CONDITIONS IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

SBH 06-003 REV.10/77 State Form 35430

EMBALMER'S NAME: JAMES M. [illegible] LICENSE No. 90

FUNERAL DIRECTOR'S SIGNATURE: [illegible] LICENSE No. 758

FILED MAR 23 1990

#1 4-30-33 1 2 0 Myocardial Infarction 3 4 Yrs 2 Mos
#2 4-6-33 1 9 0 Arteriosclerotic Heart Disease 3 4 Yrs 2 Mos
#3 4-3-33 1 2 0 Hypertension 3 4 Yrs 2 Mos
#4 4-3-33 1 2 0 Diabetes Mellitus 3 4 Yrs 2 Mos

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4.00