INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 099468 995-89   State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Mo. Day Yr)
ELIJAH	B.	THORNTON	MALE	MAY 4, 1989

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 (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
306-09-3608	82			JULY 7, 1906	YELLOW PINE, ALABAMA

8. YEAR LAST SERVED IN US ARMED FORCES? NONE

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)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
METHODIST HOSPITAL-SOUTHLAKE CAMPUS	MERRILLVILLE	LAKE

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (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	MANDA DOSHEN	STEEL WORKER	U.S. STEEL

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	MERRILLVILLE	7520 TAFT STREET

13e. INSIDE CITY LIMITS? (Yes or no)	13f. FARM	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46410	☒ No ☐ Yes	WHITE	6	

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
BUDDIE THORNTON	MILLIE ANNIE WELLS

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c. Relationship
MANDA THORNTON	7520 TAFT STREET, MERRILLVILLE, IN 46410	WIFE

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MAY 8, 1989 CALUMET PARK CEMETERY	MERRILLVILLE, INDIANA

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Robert Wiatrolik	FD01001293	FH3004455-STILINOVICH & WIATROLIK 7535 TAFT, MERRILLVILLE, IN 46410

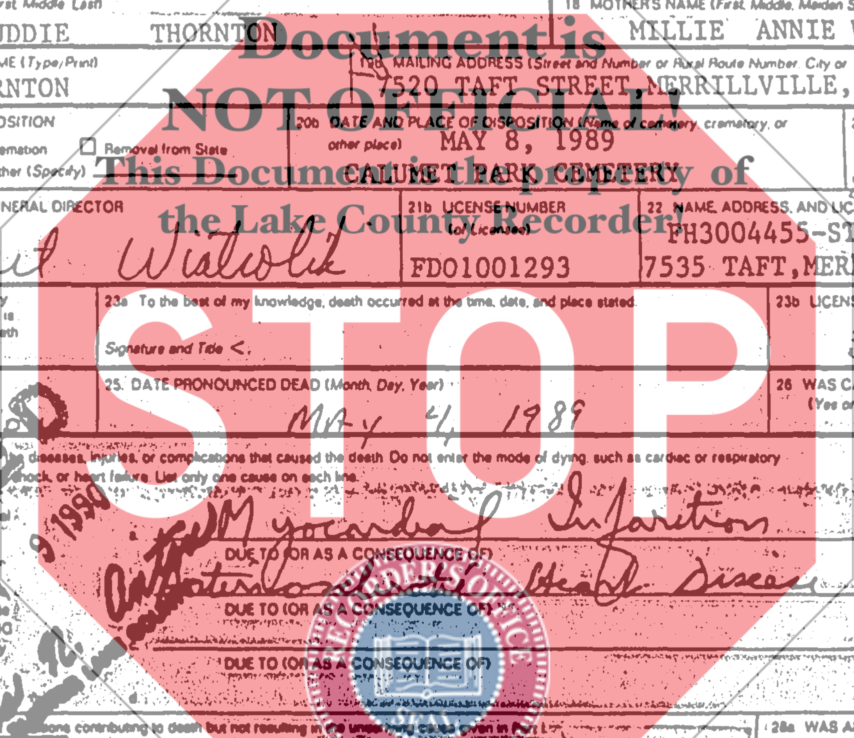
PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <   23b. LICENSE NUMBER   23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
8:00	May 4, 1989	Yes



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STOP

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Chronic Obstructive Pulmonary Disease

28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No   28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

THIS CERTIFIES THE ABOVE IS A TRUE AND ... CERTIFICATE OF ...

CERTIFIER

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD.	01029954	5.8.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
R. C. GUPTA, M.D. 6111 HARRISON STREET, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Carl A Johnson MD	May 9, 1989

CORONER OR MEDICAL EXAMINER 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 ☐ 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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1

#15-136-9 Lt 9 bl 1 Independence Hill 2nd

FILED ... 1990

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