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INDIANA STATE BOARD OF HEALTH  
CERTIFICATE OF DEATH

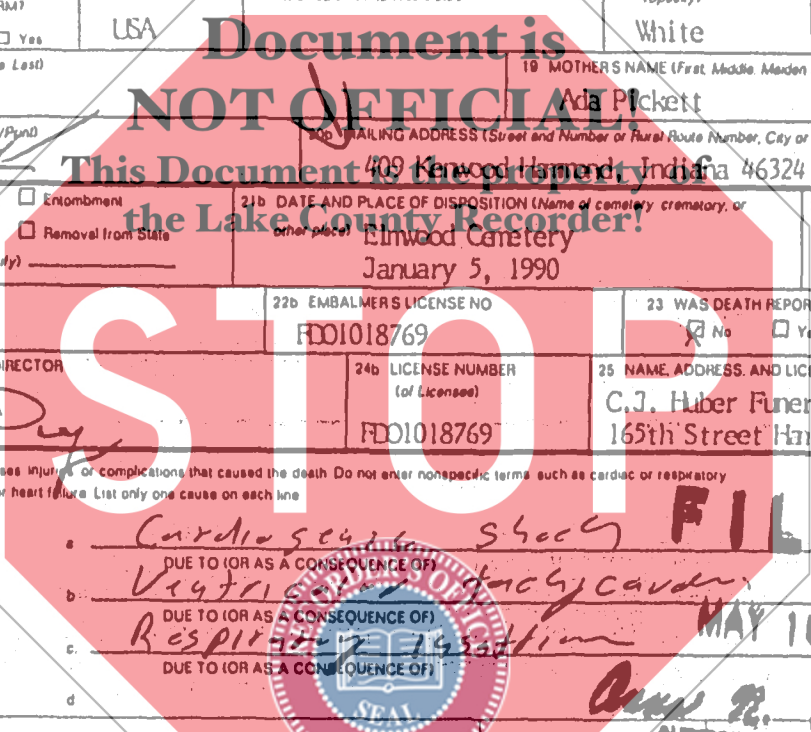
THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 4

Jan 4 1990  
Date Issued  
Franklin S. Remuda, M.D.  
Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Carl Walker		2 SEX Male	3a TIME OF DEATH 6:58 p.	3b DATE OF DEATH (Month Day Year) January 2, 1990
4 SOCIAL SECURITY NUMBER 307-01-0472	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) November 20, 1910
7 BIRTHPLACE (City and State or Foreign Country) Franklin, In.	8a WAS DECEASET A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER-Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Margaret Hospital		9c CITY/TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Verla Outler	12a DECEASET'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Engineer		12b KIND OF BUSINESS, INDUSTRY Commonwealth Edison
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 409 Kenwood	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEASET OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEASET'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9th	18 FATHER'S NAME (First Middle Last) Rufus Walker		19 MOTHER'S NAME (First Middle Maiden Surname) Ada Pickett	
20a INFORMANT'S NAME (Type/Print) Verla Walker		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Kenwood, Hammond, Indiana 46324		20c Relationship Wife
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 5, 1990 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME Rod A. Ivy		22b EMBALMER'S LICENSE NO. FD1018769		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Rod A. Ivy</i>		24b LICENSE NUMBER (of Licensee) FD1018769		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME C.J. Huber Funeral Home 722 165th Street Hammond, Indiana 46324 FDH002851
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Cardiogenic shock</i> b. <i>Ventricular tachycardia</i> c. <i>Respiratory arrest</i> d. <i>Asphyxiation</i> Conditions if any, which gave rise to the immediate cause, stating the underlying cause last.		27 WAS DECEASET PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Chronic obstructive lung disease Bladder tumor Coronary artery disease</i>		28b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes 19 hours days</i>		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>		29c MEDICAL LICENSE NO. 27640
29d DATE SIGNED (Month Day, Year) January 3, 1990		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) L. Bernstein, M.D. 5500 Hohman Avenue, Hammond, Indiana 46320		
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Remuda, M.D.</i>		32 DATE FILED (Month Day, Year) JAN 04 1990		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.		000677



FILED

MAY 10 1990

*Franklin S. Remuda*  
HEALTH OFFICER

DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Key 82-65-15 BLAINES RESUB L 33 TO 54 BY FRANKLIN S. REMUDA

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