

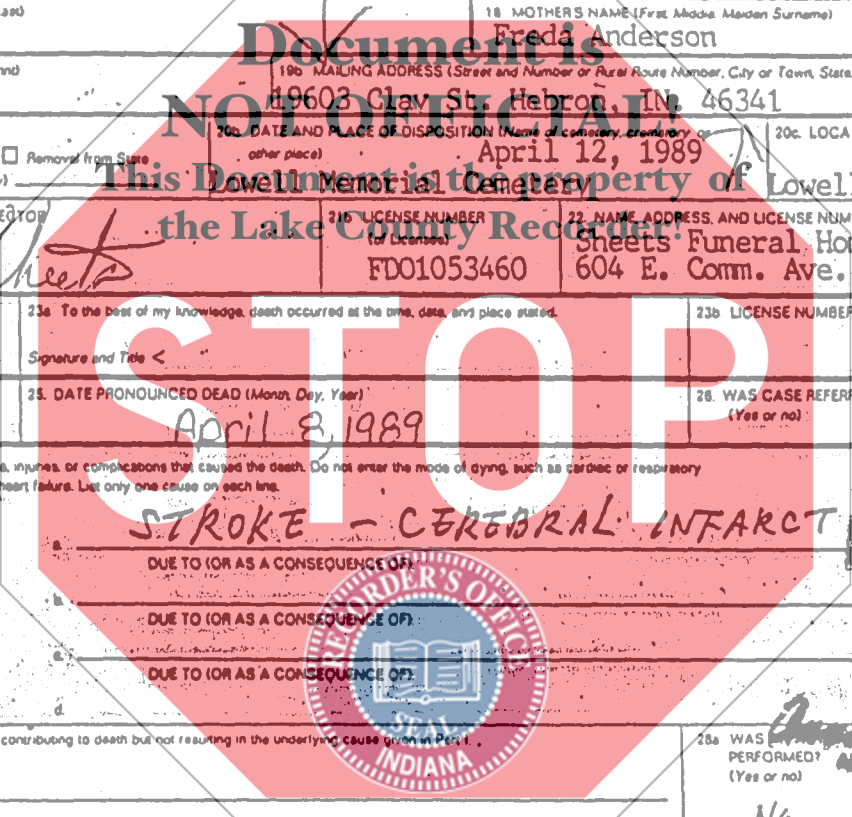
**PORTER COUNTY BOARD OF HEALTH  
CERTIFICATE OF DEATH**

**100315**

*K. Amey*  
17603 Clay St. Hebron, Ind. 46341  
**THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE**

TYPE/PRINT IN PERMANENT BLACK INK  
DECEDENT  
PARENTS  
INFORMANT  
DISPOSITION  
PRONOUNCING PHYSICIAN ONLY  
ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH  
SEE INSTRUCTIONS  
CAUSE OF DEATH  
SEE INSTRUCTIONS  
CERTIFIER  
HEALTH OFFICER  
CORONER OR MEDICAL EXAMINER USE ONLY

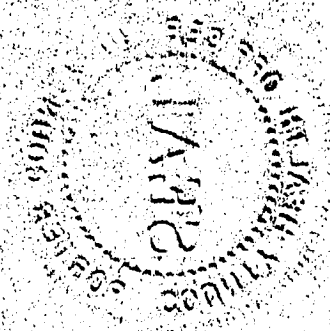
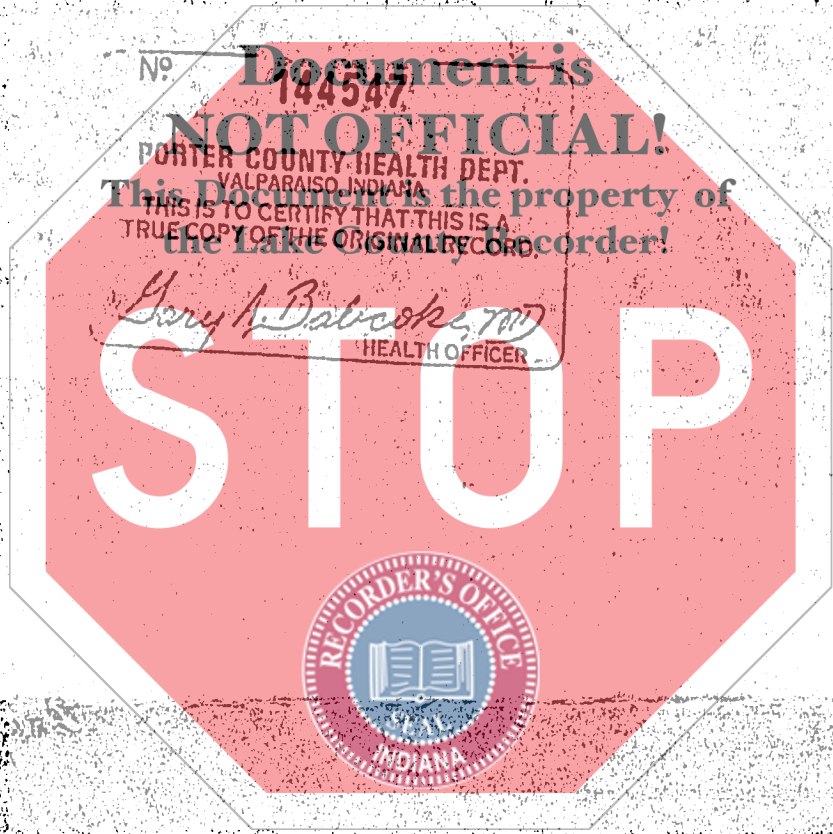
1. DECEASED—NAME FIRST: Charles A. Mamey MIDDLE: A. LAST: Mamey			2. SEX: Male	3. DATE OF DEATH (Month, Day, Year): April 8, 1989
4. SOCIAL SECURITY NUMBER: 312 38 2682	5a. AGE—Last Birthday (Years): 83	5b. UNDER 1 YEAR: Months: Days: Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year): July 22, 1905	7. BIRTHPLACE (City and State or Foreign Country): Seneca, Illinois
8. YEAR LAST SERVED IN U.S. ARMED FORCES?	9. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: <input checked="" type="checkbox"/> Porter Memorial Hospital OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
10. FACILITY NAME (If not institution, give street and number): Porter Memorial Hospital		11. CITY, TOWN OR LOCATION OF DEATH: Valparaiso	12. COUNTY OF DEATH: Porter	
13a. MARRIAGE STATUS—Married, Never Married, Widowed, Divorced (Specify): Married	13b. SURVIVING SPOUSE (If valid, give maiden name): Kathryn (Downey)	13c. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Farming	13d. KIND OF BUSINESS/INDUSTRY	
13e. RESIDENCE—STATE: Indiana	13f. COUNTY: Lake	13g. CITY, TOWN OR LOCATION: Hebron	13h. STREET AND NUMBER: 19603 Clay St.	
13i. INSIDE CITY LIMITS? (Yes or No): No	13j. FARM: Yes	13k. ZIP CODE: 46341	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.): No	15. RACE—American Indian, Black, White, etc. (Specify): White
17. FATHER'S NAME (First, Middle, Last): William Amey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Freda Anderson		
19a. INFORMANT'S NAME (Type/Print): Kathryn Mamey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19603 Clay St. Hebron, IN 46341		19c. Relationship: Wife
21a. SIGNATURE OF FUNERAL DIRECTOR: <i>W. A. Sheets</i>		21b. LICENSE NUMBER (for license): FD01053460	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, 604 E. Comm. Ave. Lowell, In. FD83004277	
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): _____	
24. TIME OF DEATH: 9:30 A.M.	25. DATE PRONOUNCED DEAD (Month, Day, Year): April 8, 1989		26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No): No	
27. PART I. Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition, resulting in death): Underlying Cause (Disease or injury that initiated events resulting in death) LAST: <b>STROKE - CEREBRAL INFARCT</b>			28. WAS AN AUTOPSY PERFORMED? (Yes or No): No	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			29. WERE ANY OTHER CAUSES OF DEATH? (Yes or No): No	
29a. CERTIFIER (Check only one): <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 27). To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> 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. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER: <i>Chen T. Sun M.D.</i>		29c. LICENSE NUMBER: 205230
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Chen T. Sun M.D., 919 S. St. Rd. 2 Hebron, In. 46341		31. HEALTH OFFICER'S SIGNATURE: <i>Robert [unclear]</i>		32. DATE FILED (Month, Day, Year): 4-17-89
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		33a. DATE OF INJURY (Month, Day, Year):	33b. TIME OF INJURY:	33c. INJURY AT WORK? (Yes or No):
33d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):		33e. DESCRIBE HOW INJURY OCCURRED: 000860		



**FILED**  
MAY 14 1989

Key 5-37-18  
 RT-S.W. Sec. 31 T 33 R 9-37-40A  
 100315-37-19 SE-SEC 31 T 33

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