K. Amey 19603 Clay St. Hebron In. 46341

PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

100315

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TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: Charles MIDDLE: A. LAST: Amey
2. SEX: Male
3. DATE OF DEATH (Mo., Day, Yr.): April 8, 1989
4. SOCIAL SECURITY NUMBER: 312 38 2682
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY 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?
9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Porter Memorial Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Kathlyn (Downey)
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Farming
12b. KIND OF BUSINESS/INDUSTRY
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hebron
13d. STREET AND NUMBER: 19603 Clay St.
13e. INSIDE CITY LIMITS? (Yes or no): No
13f. FARM: Yes
13g. ZIP CODE: 46341
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] No [ ] Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): William Amey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Freda Anderson

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Kathlyn Amey
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

DISPOSITION

20a. METHOD OF DISPOSITION [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 12, 1989 Lowell Memorial Cemetery
20c. LOCATION—City or Town, State: Lowell, In.
21a. SIGNATURE OF FUNERAL DIRECTOR: W. A. Sheets
21b. LICENSE NUMBER (of Licensee): FD01053460
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home 604 E. Comm. Ave. Lowell, In. FD83004277

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: 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

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. STROKE - CEREBRAL INFARCT
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED MAY 14 1990 AUDITOR LAKE COUNTY

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
[X] 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: Chen T. Sun MD
29c. LICENSE NUMBER: 20583
29d. DATE SIGNED (Month, Day, Year): 4/11/89
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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): 4-17-89

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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)

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

4.00

Margin notes: 3; F 40 A; Pt. SW. SW. S 31 T 33 R 9; 5-37-18; S 31-37-40A

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PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
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TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Babcock, MD
HEALTH OFFICER

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