102702

Local No. 373

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.
APR 27 1990 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Sam Jones
2 SEX: Male
3a TIME OF DEATH: 1:10 p.m.
3b DATE OF DEATH (Month Day Yr): April 25, 1990
4 SOCIAL SECURITY NUMBER: 413-07-7793
5a AGE—Last Birthday (Years): 82
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): Aug. 3, 1907
7 BIRTHPLACE (City and State or Foreign Country): Galaway, Tennessee
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1944
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ 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 (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Celeste Hankerson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer (retired)
12b KIND OF BUSINESS/INDUSTRY: LTV Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 5854 Wallace Road
13e ZIP CODE: 46320
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+):

2

PARENTS

18 FATHER'S NAME (First Middle Last): Tom Hall
19 MOTHER'S NAME (First Middle Maiden Surname): Rosie Not Available

INFORMANT

20a INFORMANT'S NAME (Type/Print): Celeste Jones
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5854 Wallace Road Hammond, Indiana 46320
20c Relationship: Wife

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!
STOP

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 30, 1990 Evergreen Memorial Park
21c LOCATION—City or Town, State: Hobart, Indiana
22a EMBALMER'S NAME: Tracy C. Williams
22b EMBALMER'S LICENSE NO: FD08600238
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cherie Williams
24b LICENSE NUMBER (of Licensee): FD08600238
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home, 4859 Alexander Avenue, East Chicago, In 46312 FH89001520

CAUSE OF DEATH

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. Ventricular Dysrythmia — Approximate Interval Between Onset and Death: 2-16-89
DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Cerebral Vascular Accident c — 2-16-89
DUE TO (OR AS A CONSEQUENCE OF)
d. Right [illegible] Paralysis, Sepsis [illegible] Catheter [illegible]

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in Part I: Diabetes Mellitus
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no
28a WAS AN AUTOPSY PERFORMED? (Yes or no): no
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): —

CERTIFIER

29a CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated.
☐ 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.
☐ 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: Lloyd [illegible], M.D.
29c MEDICAL LICENSE NO: 0101929?
29d DATE SIGNED (Month Day Year): April 4-26-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 6010 Columbia Ave, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): April 27, 90

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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 (Specify if driver, passenger, pedestrian, etc.)

FILED
MAY 29 1990
[signature]
AUDITOR LAKE COUNTY
1622

KEV #34-285-16 Lyndora Cody #16

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

4.00

This certified copy is given free of charge pursuant to law on the condition it will be used solely for Veterans benefits and or to determine eligibility for Veterans benefits.

Franklin D. Dzemenuda M.D.

Hammond Health Commissioner
Hammond, Indiana