Local No. 181-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

103568

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Bernard J. Nichols
2. SEX: Male
3a. TIME OF DEATH: 10:13A M
3b. DATE OF DEATH (Month, Day, Yr): February 15, 1990
4. SOCIAL SECURITY NUMBER: 309-22-9217
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Dec. 5, 1921
7. BIRTHPLACE (City and State or Foreign Country): Lowell, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
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): St Anthonys Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mary Beckman
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Excavating and Farming
12b. KIND OF BUSINESS/INDUSTRY: Farm
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 16805 Broadway
13e. ZIP CODE: 46356
13f. INSIDE CITY LIMITS: X No ☐ Yes
13g. ON A FARM?: ☐ No X Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? X No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Bernard Nichols
19. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Jane Turner

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary Nichols
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16805 Broadway Lowell, Indiana 46356
20c. Relationship: Spouse

DISPOSITION

21a. METHOD OF DISPOSITION: X Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 19, 1990 Lowell Memorial Cemetery
21c. LOCATION—City or Town, State: Lowell, Indiana
22a. EMBALMER'S NAME: William A. Sheets
22b. EMBALMER'S LICENSE NO.: FD01053460
23. WAS DEATH REPORTED TO CORONER? X No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] W A Sheets
24b. LICENSE NUMBER (of Licensee): FD01053460
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home FD83004277 604 E. Comm. Ave. Lowell, In. 46356

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cerebral Vascular accident (stroke)	8 hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Generalized arteriosclerosis	4 mos
DUE TO (OR AS A CONSEQUENCE OF): c.	Previous cerebral vascular accident x2	4 Mo.
DUE TO (OR AS A CONSEQUENCE OF): d.	Previous myocardial infarction	4 Mo

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: Myocardial infarction, Renal failure, Cardiomyopathy, Respiratory obstructive disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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):
X 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: [signature] Beckman
29c. MEDICAL LICENSE NO.: 21432
29d. DATE SIGNED (Month, Day, Year): 2-20-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Arthur J. Beckman MD 12110 Grant Crown Point, Indiana 46307

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] Paul A Johnson MD
32. DATE FILED (Month, Day, Year): Feb 22, 1990

FEB 22 1990

[signature] LAKE COUNTY HEALTH COMMISSIONER

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be Determined
34a. DATE OF INJURY:
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

FILED JUN 8 1 1990

[signature] AUDITOR LAKE COUNTY

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Rec. # 05-48-17 Pt. N½ NW¼ 1320X660 ft. S.15 T.32 R.8 20 Ac.

RECORDED JUN 26 ... STATE OF INDIANA S.S. NO.

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STOP

RECORDER'S OFFICE LAKE COUNTY INDIANA

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