INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 89-0142 103753 — State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME: First: Lula; Middle: Glenn; Last: Blaker
2. SEX: Female
3. DATE OF DEATH (Mo. Day, Yr.): February 26, 1989
4. SOCIAL SECURITY NUMBER: 306-28-1010
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): March 24,1919
7. BIRTHPLACE (City and State or Foreign Country): Shelby, Indiana
8. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home XX Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 3613 Calhoun Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Frank L. Blaker
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 3613 Calhoun Street
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46408
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) XX 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): N/A; College (1-4 or 5+):
17. FATHER'S NAME (First, Middle, Last): Marvin T. Latta
18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Surprise
19a. INFORMANT'S NAME (Type/Print): Frank L. Blaker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3613 Calhoun Street Gary, Indiana 46408
19c. Relationship: Spouse
20a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 1, 1989 Roselawn Cemetery
20c. LOCATION—City or Town, State: Roselawn, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): FD01053460
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home FD83004277 604 E. Comm. Ave. Lowell, In. 46356

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: 5:27 M
25. DATE PRONOUNCED DEAD (Month, Day, Year): 2-26-89
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

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. Respiratory failure — 3-5 month
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe Chronic Obstructive lung disease — 10 yrs
DUE TO (OR AS A CONSEQUENCE OF):
c. Cor pulmonale — 5 yrs
DUE TO (OR AS A CONSEQUENCE OF):
d. Pulmonary embol. Deep vein thrombosis — 1 yr

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)

29a. CERTIFIER (Check only one)
XX 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.

FILED JUN 04 1990 [signature] AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 01029166
29d. DATE SIGNED (Month, Day, Year): 2-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Hakam Safadi MD 8695 Connecticut Merrillville, Indiana 46410
31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED: MAR 08 1989

CORONER OR MEDICAL EXAMINER 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)

KEY 49-42-23 S 320 Ft of N 705 Ft of W 295 Ft of W 1/2 SE SW S 24 T 36 R 9 2.164 Ac

Stamp: ROBERT ... JUN ... STATE OF INDIANA ... FILED FOR RECORD

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

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