

INDIANA STATE BOARD OF HEALTH

a) No. 89-0142...

CERTIFICATE OF DEATH

State No.

103753

RE/PRINT IN PERMANENT INK

1 DECEASED—NAME FIRST MIDDLE LAST Lula Glenn 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
8 YEAR LAST SERVED IN U.S. ARMED FORCES?		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> 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, Married (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.) No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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+) N/A		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 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> 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 <i>[Signature]</i>		21b LICENSE NUMBER (of License) FD01053460	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home FD83004277 604 E. Comm. Ave. Lowell, In. 46356	
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 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Chronic Obstructive Lung Disease</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Cor Pulmonale</i> DUE TO (OR AS A CONSEQUENCE OF) d. <i>Pulmonary embolus</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death 3-5 month 10 yrs 5 yrs 1 yr		
28a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 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. <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.		28b. WAS AN AUTOPSY PERFORMED? (Yes or no) No		
28c. DATE SIGNED (Month, Day, Year) JUN 04 1989		28d. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? FILED		
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29b. LICENSE NUMBER 01029166	29c. 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 <i>[Signature]</i>				32. DATE SIGNED (Month, Day, Year) MAR 08 1989
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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 40 705 FT
W 295 ft W 2 SE SW
S 24 T 36 R 9 2-16-40

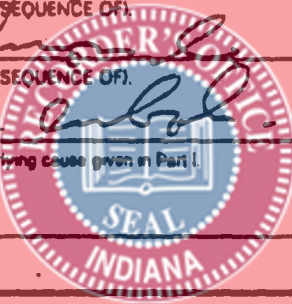
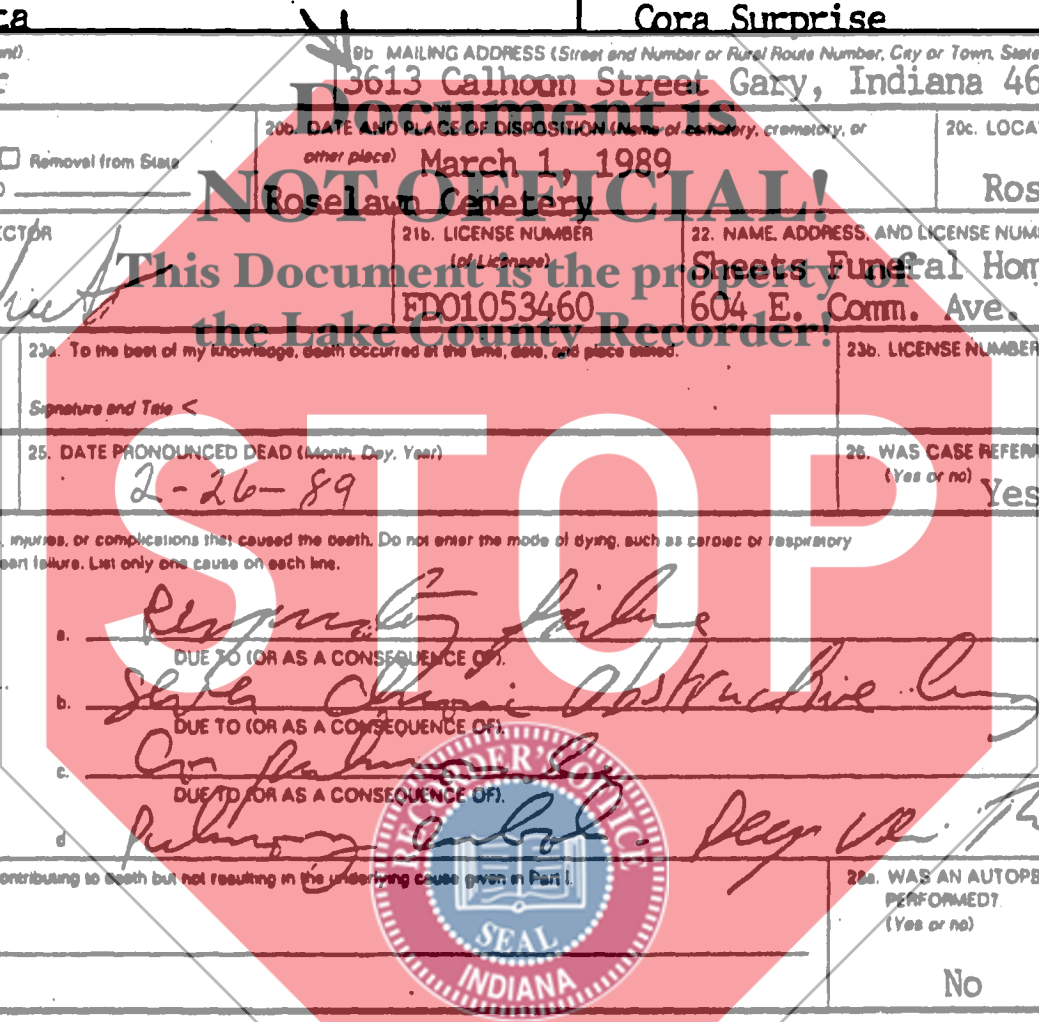
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