104428

Local No. 832-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	STANLEY POUCH
2. SEX	Male
3a. TIME OF DEATH	7:11 A.M.
3b. DATE OF DEATH (Month, Day, Yr.)	April 14, 1990
4. SOCIAL SECURITY NUMBER	713-09-5448
5a. AGE—Last Birthday (Years)	72
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	March 5, 1918
7. BIRTHPLACE (City and State or Foreign Country)	East Chicago, 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: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Anthony Medical Center
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)	Frances Olgy
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Sales Representative
12b. KIND OF BUSINESS/INDUSTRY	General Foods Corporatic
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Merrillville
13d. STREET AND NUMBER	5848 Taft Place
13e. ZIP CODE	46410
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Theodore Pouch
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Eva Shuba

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Frances Pouch
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	5848 Taft Pl., Merrillville, IN 46410
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	April 17, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State	Merrillville, Indiana
22a. EMBALMER'S NAME	Charles W. Wells
22b. EMBALMER'S LICENSE NO.	1042372
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	John [signature]
24b. LICENSE NUMBER (of Licensee)	1007231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac 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.	Endo toxic Shock	1 week
DUE TO (OR AS A CONSEQUENCE OF): b.	Ischemic bowel disease	3-MONTHS
DUE TO (OR AS A CONSEQUENCE OF): c.	Volvulus of Sigmoid Colon	
DUE TO (OR AS A CONSEQUENCE OF): d.		

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 previously stated in Part I: Anemia

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No

AUTOPSY (Yes or no): Yes

WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	William [signature]
29c. MEDICAL LICENSE NO.	8484963
29d. DATE SIGNED (Month, Day, Year)	4/16/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	William Pierce, M.D., 8683 Connecticut, Merrillville, Indiana 46410 (219) 738-2008

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month, Day, Year)	APR 16, 90

CORONER USE ONLY

Field	Entry
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? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

15-299-8 Lt #2 Lt 6 Lb 9 Am Aire Sub

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

JUN 0 1990

LAKE COUNTY HEALTH COMMISSIONER

FILED

SEAL INDIANA

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