107298

Local No. 625-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Floyd F. Foley
2. SEX: Male
3a. TIME OF DEATH: 9:35pm
3b. DATE OF DEATH (Month, Day, Yr): March 4, 1990
4. SOCIAL SECURITY NUMBER: 327-14-7264
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 4, 1922
7. BIRTHPLACE (City and State or Foreign Country): Kankakee, IL
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
8c. 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's 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): Mary A. Cross
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Manager
12b. KIND OF BUSINESS/INDUSTRY: Graphics Company
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Shelby
13d. STREET AND NUMBER: P.O. Box 112
13e. ZIP CODE: 46377
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): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3

PARENTS

18. FATHER'S NAME (First, Middle, Last): Lewis P. Foley
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rae Rose MOrris

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary Foley
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 112 Shelby, IN 46377
20c. Relationship: Spouse

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 7, 1990 Orchard Grove Cemetery
21c. LOCATION—City or Town, State: Lowell, IN
22a. EMBALMER'S NAME: William A. Sheets
22b. EMBALMER'S LICENSE NO.: FD01053460
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: W. A. Sheets
24b. LICENSE NUMBER (of Licensee): FD01053460
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, Lowell, IN

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

CAUSE OF DEATH

26. PART I. Enter the disease, 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): FILED
a. [illegible] stenosis secondary to
DUE TO (OR AS A CONSEQUENCE OF):
b. [illegible] failure
DUE TO (OR AS A CONSEQUENCE OF):
c. [illegible]
DUE TO (OR AS A CONSEQUENCE OF):

JUN 20 1990

JUN 5 1990

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.

AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH COMMISSIONER

27. WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or 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(a) 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(a) 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(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible]
29c. MEDICAL LICENSE NO.: 32265
29d. DATE SIGNED (Month, Day, Year): 3/5/90

STATE OF INDIANA/S.S. I.A. COUNTY OF LAKE/S.S. FILED FOR RECORD JUN 20 1990 OBR 33 PAGE 001340 RECORDER

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donald L. Pesavento MD 99 E. 86th Merrillville, IN 46410
31. HEALTH OFFICER'S SIGNATURE: [illegible]
32. DATE FILED (Month, Day, Year): March 15, 1990

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

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

4.00

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