137081

Garden Homes No 2
W1/2 L.4, E.25ft L.3 Both Bl.9

Rees Fun. Home, Inc
600 W Ridge Rd
Hobart In
46342

1 Occ'd

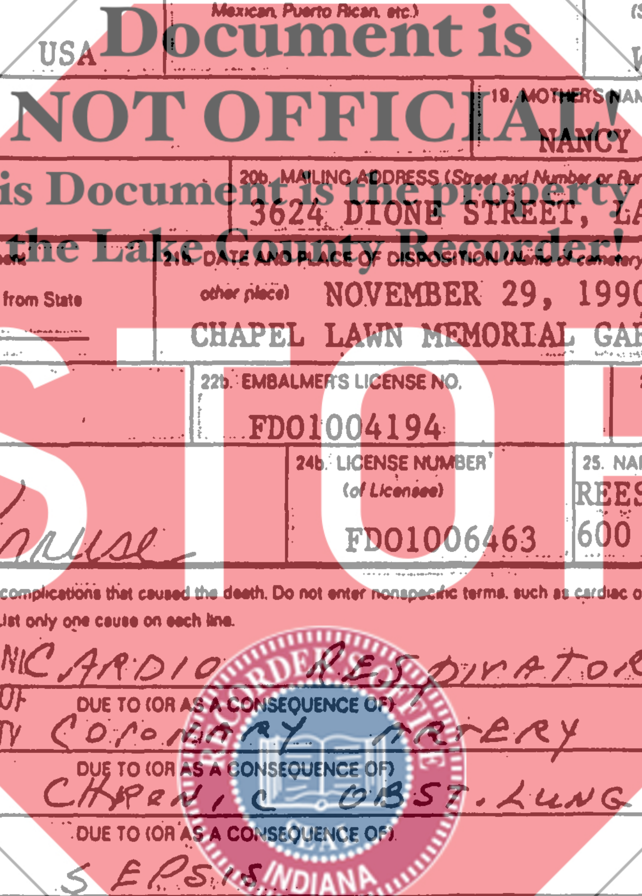
Local No. 2396-90

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Key#50-276-4 unit#35



TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	WILLIAM A. THARP
2. SEX	MALE
3a. TIME OF DEATH	11:45A M
3b. DATE OF DEATH (Month, Day, Yr)	NOVEMBER 25, 1990
4. SOCIAL SECURITY NUMBER	418-28-1034
5a. AGE—Last Birthday (Years)	69
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	MARCH 28, 1921
7. BIRTHPLACE (City and State or Foreign Country)	RED BAY, ALABAMA
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: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH	HOBART
9d. COUNTY OF DEATH	LAKE COUNTY
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	SIBYLE HESTER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	CONSTRUCTION UNIT
12b. KIND OF BUSINESS/INDUSTRY	NIPSCO
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	LAKE STATION
13d. STREET AND NUMBER	3624 DIONE STREET
13e. ZIP CODE	46405
13f. INSIDE CITY LIMITS	☐ No XX Yes
13g. ON A FARM?	XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	JOHN WILLIAM THARP
19. MOTHER'S NAME (First, Middle, Maiden Surname)	NANCY KEETON

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	SIBYLE THARP
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3624 DIONE STREET, LAKE STATION, IN 46405
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	NOVEMBER 29, 1990 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State	SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.	FD01004194
23. WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	REES FUNERAL HOMES, INC. FH83003069 600 W. RIDGE ROAD, HOBART, IN 46342

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. CARDIO RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. CORONARY ARTERY
DUE TO (OR AS A CONSEQUENCE OF):
c. CHRON, C OBST. LUNG DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d. SEPSIS

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

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	N/A

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

STATE OF INDIANA
FILED FOR RECORD
DEC 3
ROBERT ... RECORDER

CERTIFIER

29a. CERTIFIER (Check only one)
- XX 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	[signature]
29c. MEDICAL LICENSE NO.	01035471
29d. DATE SIGNED (Month, Day, Year)	11/28/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	H. SHAH, MD, 209 EAST 86TH COURT, MERRILLVILLE, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] FILED
32. DATE FILED (Month, Day, Year)	NOV. 29, 1990

CORONER USE ONLY

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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? (If yes, specify driver, passenger, pedestrian, etc.)	

DEC 3 1990
Anna N. Antonio
AUDITOR LAKE COUNTY

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