→ Samuel J. Fitzgerald

INDIANA STATE BOARD OF HEALTH

Local No. 90-0788 137100 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last): Barbara Fitzgerald			2 SEX: Female	3a TIME OF DEATH: 2:12 P.M.	3b DATE OF DEATH (Month, Day, Yr.): November 2, 1990
4 SOCIAL SECURITY NUMBER: 307-56-9234	5a AGE—Last Birthday (Years): 40	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr): July 6, 1950	7 BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a WAS DECEDENT A US VETERAN?: No	8b YEAR LAST SERVED IN US ARMED FORCES?: N/A	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): 550 Hovey Street		9c CITY, TOWN, OR LOCATION OF DEATH: Gary		9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS (Specify): Divorced	11. SURVIVING SPOUSE (If wife, give maiden name): N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Secretary		12b KIND OF BUSINESS/INDUSTRY: Methodist Hospital Northlake	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Gary		13d. STREET AND NUMBER: 550 Hovey street	
13e. ZIP CODE: 46404	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): Black	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 2 years
18 FATHER'S NAME (First, Middle, Last): Olanda Charleston				19 MOTHER'S NAME (First, Middle, Maiden Surname): Helen Louise Chambers	
20a INFORMANT'S NAME (Type/Print): Eric Fitzgerald		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 550 Hovey Street Gary, Indiana 46406			20c Relationship: Son
21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 10, 1990 Oak Hill Cemetery			21c LOCATION—City or Town, State: Gary, Indiana
22a EMBALMER'S NAME: Patrician Owens		22b. EMBALMER'S LICENSE NO.: #08700298		23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR: Valerie Brookins		24b. LICENSE NUMBER (of Licensee): #08700646		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue #83007704	

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. Congestion of lungs. — Unknown

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
b. Pending toxicology analysis and further study.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

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)
No	Yes	Pending

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

29b. SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO.	29d DATE SIGNED (Month, Day, Year)
David D. Thomas, M.D.	16120	November 9, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

31. HEALTH OFFICER'S SIGNATURE: Rebecca E. Foster MD MPH/DC

32. DATE FILED (Month, Day, Year): NOV. 8 1990

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 Ooccurred
☐ 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): November 2, 1990

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED DEC 3 1990 — Chris N. Anton AUDITOR LAKE COUNTY

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

000074

New Brunswick Add N. 20 ft. / L 30 B 13 S. 20 ft. L 31 B 13 Key # 46-70-29 Unit #25

CERTIFIED BY
HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE NOV. 16 1980