137199

Woodlawn Add
L.8, Bl. 2 + N 1/2 L.9, Bl. 2
Key #26-158-8
Unit #15

Local No: 2269-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): William Sheldon Rochford
2. SEX: Male
3a. TIME OF DEATH: 11:50A.M.
3b. DATE OF DEATH (Month, Day, Yr.): November 7, 1990
4. SOCIAL SECURITY NUMBER: 306-09-5253
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr): July 9, 1912
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Anthony Hospital
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): Martha Spitz
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired):
12b. KIND OF BUSINESS/INDUSTRY: Mills
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Griffith
13d. STREET AND NUMBER: 418 N. Griffith Blvd.
13e. ZIP CODE: 46319
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? ☒ 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+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Rochford
19. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Tompkins

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Martha Rochford
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 418 N. Griffith Blvd. Griffith, IN 46319
20c. Relationship: Wife

DISPOSITION

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 10, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Edgar C. Gleim
22b. EMBALMER'S LICENSE NO.: FD01016173
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: C. A. Kuiper
24b. LICENSE NUMBER (of Licensee): FD01014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home FDH3007500 9039 Kleinman Rd. Highland, IN 46322

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: 1 hour

DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Heart Disease — 5 years

DUE TO (OR AS A CONSEQUENCE OF):
c.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.
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): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

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.
29b. SIGNATURE AND TITLE OF CERTIFIER: E. Strimel MD
29c. MEDICAL LICENSE NO.: 18871
29d. DATE SIGNED (Month, Day, Year): 11/9/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ernest C. Miracle 1000 W 127th Pl Merrillville

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A. Johnson MD
FILED
32. DATE FILED (Month, Day, Year): Nov. 9, 1990

CORONER USE ONLY

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 bldg., 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.

DEC 4 1990

Dean R. Anton
AUDITOR LAKE COUNTY

6.00

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THIS IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
NOV 9 1990
LAKE COUNTY HEALTH COMMISSIONER

ROBERT ... DEC ... STATE ... FILED ...

SBH06.004 State Form ... DEA CERT PG 1