LTIC 50867

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

2000 Local No. 18116-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

137970

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	Donald E. Knox
2. SEX	Male
3a. TIME OF DEATH	3:30 PM
3b. DATE OF DEATH (Month Day Yr)	December 12, 1989
4. SOCIAL SECURITY NUMBER	352-12-3080
5a. AGE—Last Birthday (Years)	63
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	June 26, 1926
7. BIRTHPLACE (City and State or Foreign Country)	Sterling Illinois
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?	1945
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. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Mary Hamilton
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Supervisor
12b. KIND OF BUSINESS/INDUSTRY	US Steel
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Lake Station
13d. STREET AND NUMBER	2822 Clay St.
13e. ZIP CODE	46405
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+)	Unavailable

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	Leonard Knox
19. MOTHER'S NAME (First Middle Maiden Surname)	Gladys Shontz

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Mary Knox
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2822 Clay St. Lake Station IN 46405
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 15, 1989 Chapel Lawn
21c. LOCATION—City or Town, State	Schererville In
22a. EMBALMER'S NAME	Roger A. Young
22b. EMBALMER'S LICENSE NO.	FDO 8601323
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Roger A. Young (signature)
24b. LICENSE NUMBER (of Licensee)	FD08601323
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Young Funeral Home FH83001643 1307 Central Ave Lake Station IN 46405

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) Ventricular fibrillation ... myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):
(b) [illegible]

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED NOV 30 1990

Anna M. Antone (signature)
AUDITOR LAKE COUNTY

DEC 14 1989

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

(signature) LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA

CERTIFIER

29a. CERTIFIER (Check only one)
☒ PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) 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	E. F. Schulte M.D. (signature)
29c. MEDICAL LICENSE NO.	01035204
29d. DATE SIGNED (Month, Day, Year)	12/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Eric F. Schulte 7863 Broadway Merrillville IN

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	(signature)
32. DATE FILED (Month, Day, Year)	DEC 14, 89

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 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.

Key #s 19-87-7-8 Lot 7 & 8 Bl. 3
3rd Subdiv. East Gary

001527

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