Local No. 538 138663

# INDIANA STATE BOARD OF HEALTH
## CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Nov 26 1990 — Franklin D. Jemison M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME: First: Bert; Middle: E. A.; Last: Hindmarch
2. SEX: Male
3. DATE OF DEATH (Mo., Day, Yr.): July 13, 1989
4. SOCIAL SECURITY NUMBER: 306-01-6273
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): Oct. 20, 1913
7. BIRTHPLACE (City and State or Foreign Country): Ft. Wayne, Indiana
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Margery Shock
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Professor
12b. KIND OF BUSINESS/INDUSTRY: Purdue-Calumet
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7018 Knickerbocker Pkwy.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46323
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or, Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5+

**PARENTS**

17. FATHER'S NAME (First, Middle, Last): John Daniel Hindmarch
18. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia Dressler

**INFORMANT**

19a. INFORMANT'S NAME (Type/Print): Margery Hindmarch
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7018 Knickerbocker Pkwy Hammond, IN 46323
19c. Relationship: Wife

**DISPOSITION**

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 17, 1989 Elmwood Cemetery
20c. LOCATION—City or Town, State: Hammond, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: Thomas
21b. LICENSE NUMBER (of Licensee): 10457
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Homes, Inc. Munster, Indiana 3004968

**PHYSICIAN ONLY**

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title:
23b. LICENSE NUMBER:
23c. DATE SIGNED (Month, Day, Year):
24. TIME OF DEATH: 6:00 p.m.
25. DATE PRONOUNCED DEAD (Month, Day, Year): July 13, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

**CAUSE OF DEATH**

SEE INSTRUCTIONS

27. PART I. Enter the disease(s), injuries, or complications that caused the death. Do not enter the mode of dying, 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. Chronic lymphatic leukemia
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death: a. 5 yr; b. ; c. ; d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

**CERTIFIER**

29a. CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Lanman MD
29c. LICENSE NUMBER: 16203
29d. DATE SIGNED (Month, Day, Year): July 14, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J. Lanman, MD. 716 Seberger Drive, Munster, Indiana 46321

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jemison M.D.
32. DATE FILED (Month, Day, Year): JULY-14-89

**CORONER OR MEDICAL EXAMINER 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):

00346

SBH06-004 State Form 10110 (R/10-87) DEATH/PD 1

Pinkerton & Freedman
7900 Indianapolis Blvd Hammond 46322