Thelma June Futrell

Local No. 1501-99139188

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Jack C. Futrell Sr.
2. SEX: Male
3a. TIME OF DEATH: 06:45A M
3b. DATE OF DEATH (Month, Day, Yr.): July 14, 1990
4. SOCIAL SECURITY NUMBER: 378-28-1562
5a. AGE—Last Birthday (Years): 58
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): SEP 12, 1931
7. BIRTHPLACE (City and State or Foreign Country): Crystal Valley, MI
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1952
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): Mercy Hospital
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): Thelma June Pierce
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver
12b. KIND OF BUSINESS/INDUSTRY: Teamsters #142
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 3332 Connecticut
13e. ZIP CODE: 46409
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Bert Futrell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Marian

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Thelma June Futrell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3332 Connecticut, Gary, Indiana 46409
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JUL 17 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana 4641
22a. EMBALMER'S NAME: Robert Wiatrolik
22b. LICENSE NUMBER: FDE 1001293
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b. LICENSE NUMBER (of Licensee): FDE1001293
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH3004455 Stilinovich & Wiatrolik Funeral Home 7535 Taft Street, Merrillville, IN 4641

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Acute Myocardial Infarction x 3 — Approximate Interval Between Onset and Death: 8 [illegible]
DUE TO (OR AS A CONSEQUENCE OF): Cardio Atherosclerosis
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

PART II. Other significant conditions
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)

I CERTIFY THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE [illegible] HEALTH DEPT. JUL 23 1990 — COUNTY HEALTH COMMISSIONER

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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: [signature]
29c. MEDICAL LICENSE NO.: 25673
29d. DATE SIGNED (Month, Day, Year): 7/16/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Hamang, 904 W. Ridge Road, Hobart, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: FILED [signature]
32. DATE FILED (Month, Day, Year): July 18, 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): DEC 17 1990
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.

00816

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

Broadway Parkview L.5 + L.7, Block 28
Key#41-207-547, unit#25
Riverview Land + Inv. Co. 1st Add. all L.1 + L.2, Bl. 7
Key# 46-467-1, unit#25

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