

Key # 46-400-0041
Local No. 2103-970

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

14
Red Oak Add L. 42 B1.8
Key # 46-400-41, unit # 25
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) John Paul Jones		2 SEX Male	3a TIME OF DEATH 5:00 P M	3b DATE OF DEATH (Month, Day, Yr) October 16, 1990
4 SOCIAL SECURITY NUMBER 332-12-4622	5a AGE—Last Birthday (Years) 81	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Mar. 3, 1909
7 BIRTHPLACE (City and State or Foreign Country) UNK Kentucky	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) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake Campus		9c CITY, TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Estelle Manning	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Iron Worker	12b KIND OF BUSINESS/INDUSTRY Union	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 3880 Harrison	
13e ZIP CODE 46408	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNK College (1-4 or 5+) UNK	18 FATHER'S NAME (First, Middle, Last) William Jones		19 MOTHER'S NAME (First, Middle, Maiden Surname) Ursula Razor	
20a INFORMANT'S NAME (Type/Print) Estelle Jones	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3880 Harrison Gary Indiana		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) October 19, 1990 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN.	
22a EMBALMER'S NAME Ronald A. Reed	22b EMBALMER'S LICENSE NO. FDO 1001081	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b LICENSE NUMBER (of Licensee) FDO 1014511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland Indiana 46130-7500		
26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as "cardiac arrest," "shock," or "heart failure." List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		27 WAS DECEDENT LAKE COUNTY INDIAN AUTOPSY PERFORMED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
26 PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		28a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 min		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i> M.D.		29c MEDICAL LICENSE NO. 01038025
29d DATE SIGNED (Month, Day, Year) 10/18/90		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ADOLPH R. YANER 5490 Broadway Merrillville IN 46410		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month, Day, Year)		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	34a DATE OF INJURY (Month, Day, Year) FEB 22 1991	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) FEB 22 1991		34f LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34g DATE PRONOUNCED DEAD (Month, Day, Year) Anna M. Anton		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 01339		

