

TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

91009356

INDIANA STATE BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

State No. 120

Local No. 784

Below for State Office Use

FUNERAL HOME  
No. 496

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

FILED  
FEB 28 1981

4518

LICENSE No. 15-339-18

FUNERAL DIRECTOR'S  
LICENSE No. 2881

USUAL RESIDENCE WHERE DECEASED DIED, OR PLACE OF DEATH IF OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

PARENTS

DISPOSITION

M.D.  
OR  
D.O.

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

EMBALMER'S NAME Thomas J. Burns

FUNERAL DIRECTOR'S SIGNATURE Frank J. Kish

|  |  |  |  |   |   |   |
|--|--|--|--|---|---|---|
| 1. DECEASED—NAME<br>FIRST MIDDLE LAST<br><b>CHALMERS GARD</b>  |  |  | 2. SEX<br><b>Male</b>  |   | DATE OF DEATH (MONTH, DAY, YEAR)<br><b>October 19, 1980</b> |   |
| 3. RACE—(e.g. White, Black, American Indian, etc.) (Specify)<br><b>White</b>   |  | 4. AGE—Last Birthday (Yrs.)<br><b>66</b>   |  | 5. DATE OF BIRTH (Mo., Day, Yr.)<br><b>8/20/1914</b>                        |   | 6. COUNTY OF DEATH<br><b>Lake</b>   |
| 7a. CITY, TOWN OR LOCATION OF DEATH<br><b>Hammond</b>  |  |  | 7b. HOSPITAL OR OTHER INSTITUTION—(Name if not in index, give street and number)<br><b>St. Margaret Hospital</b> |   |   | 7c. IF HOSP. OR INST. Indicate DOA, OP/Emar. Pm., Inpatient (Specify)<br><b>Inpatient</b>           |
| 8. STATE OF BIRTH (If not in U.S.A. name country)<br><b>Iowa</b>   |  | 9. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  | 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   |   | 11. SURVIVING SPOUSE (If wife, give maiden name)<br><b>Theresa Pistone</b>                          |
| 12. SOCIAL SECURITY NUMBER<br><b>307-01-2802</b>   |  |  | 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sales</b>       |   | 14. KIND OF BUSINESS OR INDUSTRY<br><b>Automobile</b>       |   |
| 15a. RESIDENCE—STATE<br><b>Indiana</b>   |  | 15b. COUNTY<br><b>Lake</b>   |  | 15c. CITY, TOWN OR LOCATION<br><b>Merrillville, In</b>                      |   | 15d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 16a. STREET AND NUMBER<br><b>3628 W. 79th Street</b>   |  |  | 16b. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |   |   | 16c. INSIDE CITY LIMITS (Specify Yes or No)<br><b>Yes</b>   |
| 17. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC.<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |   |   |
| 18. FATHER—NAME<br>FIRST MIDDLE LAST<br><b>George E. Gard</b>  |  | 19. MOTHER—MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl Bright</b>   |  | 20. INFORMANT—NAME (Type or print)<br><b>Theresa Gard</b>                   |   |   |
| 21a. MAILING ADDRESS<br><b>3628 W. 79th St.</b>  |  | 21b. CITY OR TOWN<br><b>Merrillville, In</b>   |  | 21c. STATE<br><b>46410</b>  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br><b>Burial</b>  |  | 22b. CEMETERY OR CREMATORY—FUNERAL HOME<br><b>Memory Lane</b>  |  | 22c. LOCATION<br><b>Schererville, In</b>                                    |   |   |
| 23a. DATE (MONTH, DAY, YEAR)<br><b>October 22, 1980</b>  |  | 23b. FUNERAL HOME—NAME AND ADDRESS<br><b>Burns-Kish Funeral Homes, Inc.</b>  |  | 23c. (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)<br><b>Munster, In</b> |   |   |
| 24. To the best of my knowledge, death occurred at the time, date and place as given to the coroner's agent.<br>NAME OF ATTENDING PHYSICIAN (Type or Print)<br><b>Howard M. Diamond, M.D.</b>                              |  |  | 24a. DATE SIGNED (Mo., Day, Yr.)<br><b>10-19-80</b>  |   | 24b. HOUR OF DEATH<br><b>5:10 AM</b>                        |   |
| 25. MAILING ADDRESS—PHYSICIAN<br><b>7905 Calumet Avenue, Munster, Ind 46321</b>  |  |  | 26. HEALTH OFFICER'S SIGNATURE<br><b>[Signature]</b>   |   |   |   |
| 27. HEALTH OFFICER'S SIGNATURE<br><b>[Signature]</b>   |  |  | 28. DATE RECEIVED BY LOCAL HEALTH OFFICER<br><b>OCT 21 1980</b>  |   |   |   |
| 29. IMMEDIATE CAUSE<br>PART I<br>(a) <b>CARDIO-PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>CACHEXIA</b><br>DUE TO OR AS A CONSEQUENCE OF:<br>(c) <b>METASTATIC ADENOCARCINOMA OF PROSTATE GLAND</b> |  | 30. OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)<br><b>RENAL INSUFFICIENCY</b> |  | 31. INTERVAL BETWEEN ONSET AND DEATH  |   | 32. AUTOPSY (Specify Yes or No)<br><b>No</b>  |

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPT.

Disposition Permit Issued  /

Provisional Certificate  Yes  No

609