91015752

Local No. 0703-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

KEY 50-142-4 1ST ADD EAST GARY GARDENS LOTS 5+6 BL. 21

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
MITCH	V.	AKINS	Male	7:50P M	March 27, 1991

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
334-16-8690	69			MAY 17, 1921	GALATIA, ILLINOIS

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	8a PLACE OF DEATH (Check only one See instructions)
Yes	1945	HOSPITAL [X] Inpatient [ ] ER Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	BETTY WILSON	PRESS OPERATOR	BUD PLANT

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	LAKE STATION	2516 CASS ST.

13e ZIP CODE	13f INSIDE CITY LIMITS	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)
46405	[ ] No [X] Yes; 13g ON A FARM? [X] No [ ] Yes	USA	[X] No [ ] Yes	WHITE	Elementary/Secondary (0-12): 6; College (1-4 or 5+):

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
JASPER AKINS	ELLA BISHOP

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
GARY D. AKINS	2284 SLOAN ST., PORTAGE, IN 46368	Son

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION (City or Town State)
[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)	MAR 30 1991 CALVARY CEMETERY	PORTAGE INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FD01004194	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James G. Krause	FD01006463	FH83003069 REES FUNERAL HOMES INC. 600 W. OLD RIDGE RD, HOBART, IN 46342

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. Coronary Occlusion

DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF)
c.

DUE TO (OR AS A CONSEQUENCE OF)
d.

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

Approximate Interval Between Onset and Death: APR 1 1991

I CERTIFIES THE ABOVE IS A TRUE COPY OF THE CERTIFICATE OF ... ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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

Chronic pulmonary fibrosis with Emphysema

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
N/A	NO	N/A

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	29c. MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Robert A. Penn, MD	0101915	4-1-91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
ROBERT A. PENN MD, 3820 CENTRAL AVENUE, LAKE STATION, IN 46405

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
Alexander S. Williams, MD	April 1, 1991

FILED

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
[X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				APR 4 1991

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)
	600

34g DATE PRONOUNCED DEAD (Month Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian etc
	Agnes N. Antone AUDITOR LAKE COUNTY 00355

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