91020550 (10)

Local No. 298

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.

APR 22 1991
Date Issued

Franklin D. Spremulli M.D.
Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): William Motley
2 SEX: Male
3a TIME OF DEATH: 12:36 PM
3b DATE OF DEATH (Month, Day, Yr.): April 20, 1991
4 SOCIAL SECURITY NUMBER: 313-20-8791
5a AGE—Last Birthday (Years): 65
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day, Yr.): October 2, 1925
7 BIRTHPLACE (City and State or Foreign Country): Indianapolis, Indiana
8a WAS DECEDENT A US VETERAN?: Yes
8b YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): St. Margaret Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Joan Wilson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Control Room Operator (ret)
12b KIND OF BUSINESS/INDUSTRY: American Maize Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 330 Waite Street
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS? [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5 +):

PARENTS

18 FATHERS NAME (First, Middle, Last): Herbert Motley
19 MOTHERS NAME (First, Middle, Maiden Surname): Hazel Fuqua

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joan Motley
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 330 Waite Street Gary, Indiana 46404
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): April 23, 1991 Oak Hill Crematory
21c LOCATION—City or Town, State: Gary, Indiana
22a EMBALMER'S NAME: Tracy Cheri Williams
22b EMBALMER'S LICENSE NO.: FD08600238
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b LICENSE NUMBER (of Licensee): FD08600238
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton & Williams Funeral Home 4859 Alexander Avenue FH83001520 East Chicago, Indiana 46312

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 arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Pulmonary insufficiency & pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Carcinoma of the right lung & Metastasis
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Remote Coronary by angiff.

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

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not previously stated in PART I.

27 WAS DECEDENT PREGNANT, OR 60 DAYS POSTPARTUM? (Yes or no): 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): ------

FILED
APR 30 1991
Anna M. Anderson
AUDITOR LAKE COUNTY

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: A. M. Branco M.D.
29c MEDICAL LICENSE NO: 20253
29d DATE SIGNED (Month, Day, Year): April 4-22-91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.M. Branco, M.D. 7905 Calumet Avenue, Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Spremulli M.D.
32 DATE FILED (Month, Day, Year): APR 22 1991

CORONER USE ONLY

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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): 600
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

L.I. Combs & Sons 3rd Sub
L. 14 Blk Key#42-315-14 Unit#25

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SBH00-004 State Form 10110 (R2/3-89) DEA CERT/PD 1