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91021002

INDIANA STATE BOARD OF HEALTH

N. BARBER
517 N. MAIN ST
Crown Point, IN 46307

Local No. 27-30-90

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) Hester Daugherty Courtright		2. SEX Female	3a. TIME OF DEATH 9:53 A.M.	3b. DATE OF DEATH (Month, Day, Yr) October 30, 1990	
4. SOCIAL SECURITY NUMBER 312-30-6360	5a. AGE—Last Birthday (Years) 88	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) May 19, 1902	
7. BIRTHPLACE (City and State or Foreign Country) Crown Point, Indiana	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) St. Anthony Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Widowed	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) High School Teacher	12b. KIND OF BUSINESS/INDUSTRY Public School System		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Crown Point	13d. STREET AND NUMBER 126 Elmwood Place		
13a. ZIP CODE 46307	13b. 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): College (1-4 or 5+): 5+		18. FATHER'S NAME (First, Middle, Last) Charles J. Daugherty			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Evans			20. INFORMANT'S NAME (Type/Print) Sister M. Katharine Courtright		
20. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Elmwood Place, Crown Point, In. 46307		20c. Relationship Daughter			
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 (Date of death, cemetery, or other place) November 2, 1990 St. Mary Cemetery		21c. LOCATION—City or Town, State Crown Point, Indiana	
22a. EMBALMER'S NAME Dennis P. Lapine		22b. EMBALMER'S LICENSE NO. FD08700141	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>William C. Geisen</i>		24b. LICENSE NUMBER (of Licensee) FD01003203	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83907762 7905 Broadway, Merrillville, In. 46410		
26. PART I. Enter the disease, 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) <i>Cardiogenic shock</i> THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH TO BE FILED WITH THE LAKE COUNTY HEALTH DEPT. DUE TO (OR AS A CONSEQUENCE OF) <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____					
PART II. Other significant conditions contributing to death but not previously stated in Part I. <i>1990</i>			27. WAS DECEDENT PREGNANT OR 90 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).			29. CERTIFY that the above is the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input checked="" 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.		
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Manuel B. Gabato, M.D.</i>		29b. MEDICAL LICENSE NO. 0102738	29c. DATE SIGNED (Month, Day, Year) 11/3/90		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Manuel B. Gabato, M.D., 12110 Grant Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Manuel B. Gabato, M.D.</i>			32. DATE FILED (Month, Day, Year) November 7, 1990		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) FILED	34d. DESCRIBE HOW INJURY OCCURRED FILED
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) MAY 2 1991			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, driver's license number <i>00143</i> AUDITOR LAKE COUNTY			

DECEDENT

PARENTS

INFORMANT

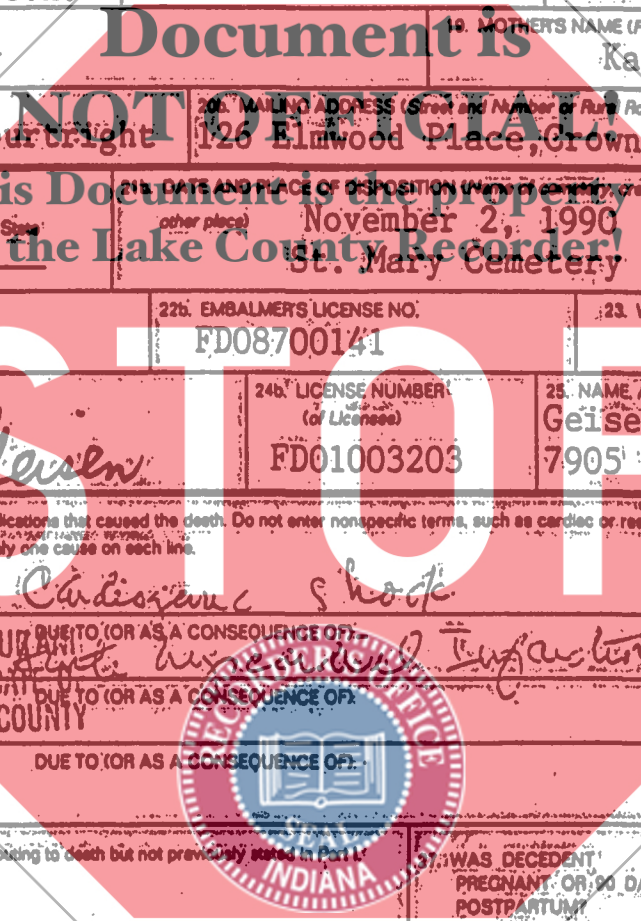
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



KEY 9-29-5
L.M.W.O.P.
W. 55 FT. OF LOT 4

OFFICE OF THE
RECORDER
LAKE COUNTY, INDIANA
MAY 2 1991
APPROPRIATE
INTERVAL BETWEEN
DEATH AND DEATH
CERTIFICATE
LESS THAN 24 HRS

600