

91021127

4388-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No.

1000

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) MARVIN E. THORNTON				2. SEX MALE	3a. TIME OF DEATH 12:00P M	3b. DATE OF DEATH (Month, Day, Yr) OCTOBER 18, 1989	
4. SOCIAL SECURITY NUMBER 236-09-8276	5a. AGE—Last Birthday (Years) 83	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) NOV 30, 1905	7. BIRTHPLACE (City and State or Foreign Country) NICHOLAS COUNTY, WEST VIRGINIA		
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See instructions)					
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) MARY L. MURPHY	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SHEARMAN		12b. KIND OF BUSINESS/INDUSTRY US STEEL			
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION LAKE STATION		13d. STREET AND NUMBER 3518 MINNESOTA STREET			
13e. ZIP CODE 46405	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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)		
18. FATHER'S NAME (First, Middle, Last) THOMAS THORNTON		19. MOTHER'S NAME (First, Middle, Maiden Surname) ETTA PERKINS		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 4 College (13 or 5+)			
20a. INFORMANT'S NAME (Type/Print) MARY L. THORNTON		20b. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3518 MINNESOTA STREET, LAKE STATION, IN 46405		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 21, 1989 EVERGREEN MEMORIAL PARK		21c. LOCATION—City or Town, State HOBART, INDIANA			
22a. EMBALMER'S NAME JAMES W. GHOLSON		22b. EMBALMER'S LICENSE NO. FDO1004194		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Gerald D. Rice</i>		24b. LICENSE NUMBER (of Licensee) FDO1041083		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME, INC. 600 W. 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. RESPIRATORY FAILURE		26. PART I. (Continued)		Approximate Interval Between Onset and Death 2 1/2			
26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. CARCINOMA, BLADDER		27. WAS DECEDENT PREGNANT OR POSTPARTUM (Yes or no) N/A		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jacob E. Pruitt</i>		29c. MEDICAL LICENSE NO. 15267		29d. DATE SIGNED (Month, Day, Year) 10-20-89			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) JACOB E. PRUITT, MD, 7895 BROADWAY, MERRILLVILLE, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>					32. DATE FILED (Month, Day, Year) Oct. 20, 1989		
33. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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)					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

KEY 50-201-3
SPELMAN'S MOO
TO GARY
N 10' LOT 38
ALL LOT 39 & 51077 LOT 40
BLOCK 3

PARENTS

INFORMANT

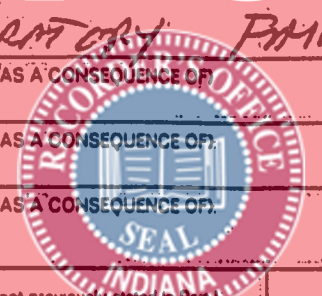
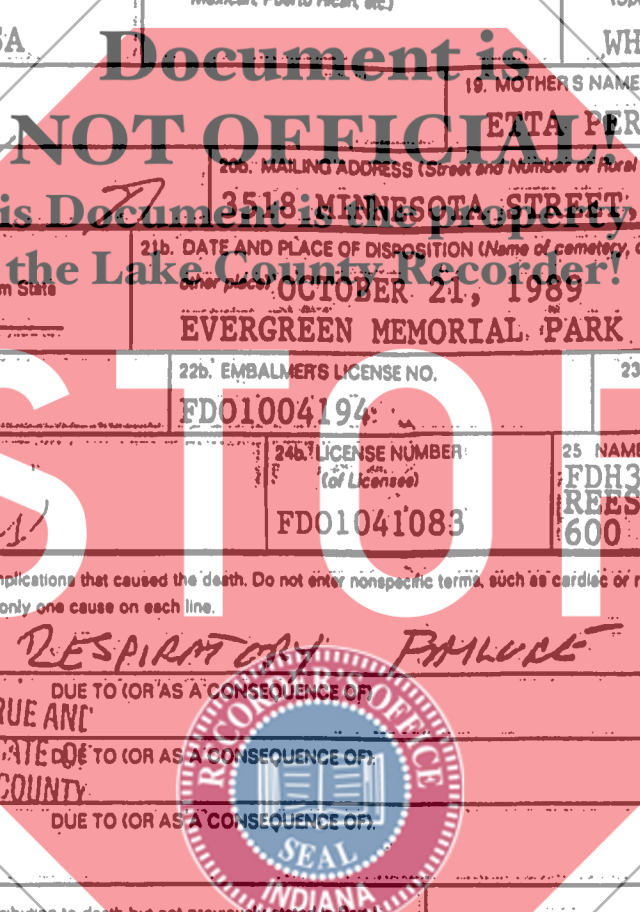
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



FILED

MAY 3 1991

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