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Local No. 4388-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
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: [ ] 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): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):

KEY 50-201-3 SPIELMANS ADD TO GARY N 1/2 LOT 38 ALL LOT 39 & S 10 FT LOT 40 BLOCK 3

PARENTS

18. FATHER'S NAME (First, Middle, Last): THOMAS THORNTON
19. MOTHER'S NAME (First, Middle, Maiden Surname): ETTA PERKINS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARY L. THORNTON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3518 MINNESOTA STREET, LAKE STATION, IN 46405
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] 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.: FD01004194
23. WAS DEATH REPORTED TO CORONER?: [ ] No [X] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Elmer A. Rees
24b. LICENSE NUMBER (of Licensee): FD01041083
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FDH3003069 REES FUNERAL HOME, INC. 600 W. RIDGE RD, HOBART, IN 46342

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. RESPIRATORY FAILURE — Approximate Interval Between Onset and Death: 24h.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA — DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: SMOKING MAY BLADDER CANCER

27. WAS DECEDENT PREGNANT OR WITHIN 1 YEAR OF DEATH? (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

CERTIFIER

29a. CERTIFIER (Check only one): [ ] CERTIFYING PHYSICIAN [X] LAKE COUNTY HEALTH COMMISSIONER [ ] HEALTH OFFICER [ ] CORONER
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
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.
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: Carl F. Johnson
29c. MEDICAL LICENSE NO.: 15267
29d. DATE SIGNED (Month, Day, Year): 10-20-89

HEALTH OFFICER

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: Carl F. Johnson
32. DATE FILED (Month, Day, Year): Oct. 20 1989

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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 Ooccurred:
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.:

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