91021999

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 719-90 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First, Middle, Last)	David D. McSparron
2. SEX	Male
3a. TIME OF DEATH	5:30 a.m.
3b. DATE OF DEATH (Month, Day, Yr.)	March 26, 1990
4. SOCIAL SECURITY NUMBER	501-03-4104
5a. AGE—Last Birthday (Years)	85
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr.)	June 6, 1904
7. BIRTHPLACE (City and State or Foreign Country)	Grandin, No Dakota
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1944
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Mary's Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Bonnie Perry
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Retired Supervisor
12b. KIND OF BUSINESS/INDUSTRY	U.S. Steel Co.
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	430 E. 53rd Ave.
13e. ZIP CODE	46409
13f. INSIDE CITY LIMITS?	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	Andrew McSparron
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Jesse MacFarlane

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Bonnie McSparron
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	430 E. 53rd Ave. Gary, In 46409
20c. Relationship	Wife

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March 29, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State	Merrillville, Ind.
22a. EMBALMER'S NAME	Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.	FD01010402
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Anthony S. Rendina Jr. (signature)
24b. LICENSE NUMBER (of Licensee)	FH83007819
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Rendina F. Home FH83007819, 5100 Cleveland St. Gary, In 46408

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) / Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — Approximate Interval Between Onset and Death

a. Cerebral Thrombosis / Infarction
b. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia
c. DUE TO (OR AS A CONSEQUENCE OF): Uremia
d. DUE TO (OR AS A CONSEQUENCE OF): Bleeding Peptic Ulcer

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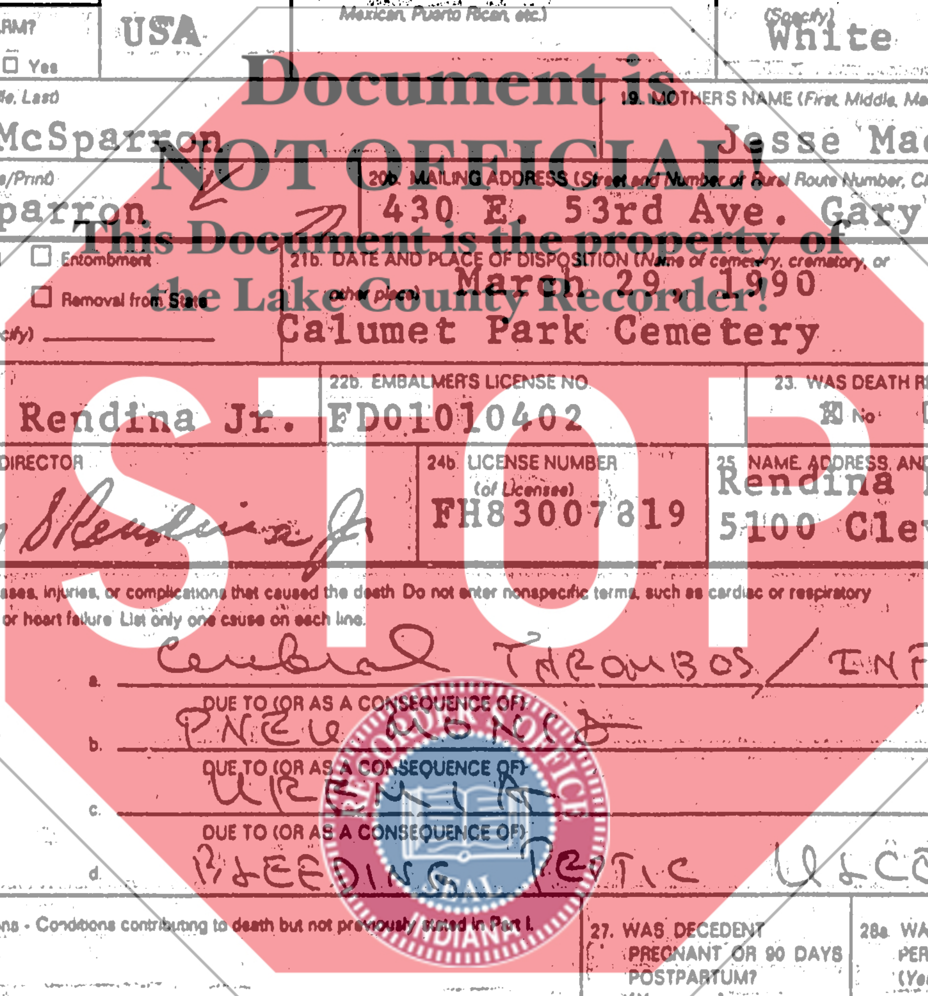
PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I.

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



CERTIFIER

29a. CERTIFIER (Check only one)
- ☐ 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: (signature) MD
29c. MEDICAL LICENSE NO.: 26118
29d. DATE SIGNED (Month, Day, Year): 3-26-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. 1400 S. LAKE PARK AVE. HOBART, IND. 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: (signature)
32. DATE FILED (Month, Day, Year): March 25, 1990

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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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

LAKE COUNTY HEALTH COMMISSIONER (signature)

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Key # 46-583-30 Woodlawn Manor Unit 1 Lot 30 Bl D

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1