

91022016

91-0318

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. ....

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>John D. Johnson</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>8:50 P.M.</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>April 17, 1991</b>
4. SOCIAL SECURITY NUMBER <b>054-01-7953</b>	5a. AGE—Last Birthday (Years) <b>87</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Feb. 15, 1904</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Louisiana</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c. 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		

DECEDENT

9b. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital Northlake</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Gary</b>	9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>O. T. Parker</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>:Laborer</b>	12b. KIND OF BUSINESS/INDUSTRY <b>LTV Steel Corp.</b>

PARENTS

13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Gary</b>	13d. STREET AND NUMBER <b>1105 West 11th Avenue</b>
13e. ZIP CODE <b>46404</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>Black</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)		

INFORMANT

18. FATHER'S NAME (First, Middle, Last) <b>(Unknown)</b>	19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Wilder</b>	
20a. INFORMANT'S NAME (Type/Print) <b>O. T. Johnson</b>	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1105 W. 11th Avenue Gary, Indiana 46404</b>	20c. Relationship <b>Wife</b>

DISPOSITION

21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>April 19, 1991 Oak Hill Cemetery</b>	21c. LOCATION—City or Town, State <b>Gary, Indiana</b>
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CAUSE OF DEATH

22a. EMBALMER'S NAME <b>Patricia Gans</b>	22b. EMBALMER'S LICENSE NO. <b>#08700298</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b. LICENSE NUMBER (of Licensee) <b>08700646</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Guy &amp; Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404 83007704</b>

CERTIFIER

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 cause on each line. <b>Congestive Cardiac Failure arteriosclerotic heart disease</b>		Approximate Interval Between Onset and Death <b>7-8</b>
IMMEDIATE CAUSE (Disease or condition immediately resulting in death) <b>Congestive Cardiac Failure</b>		STATE OF INDIANA LAKE COUNTY FILED MAY 8 1991 RECORDS
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <b>arteriosclerotic heart disease</b>		
PART II. Other significant conditions - Conditions contributing to death but not previously mentioned in Part I. <b>arteriosclerotic heart disease</b>		

HEALTH OFFICER

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

29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input 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.	29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>	29c. MEDICAL LICENSE NO. <b>IN 25043</b>	29d. DATE SIGNED (Month, Day, Year) <b>4/22/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>KRISTIAN T. FOTTI MD 8300 Broadway, Merrillville, IN 46410</b>		32. DATE FILED (Month, Day, Year) <b>APR. 25 1991</b>	
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>	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)	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.		



CERTIFIED BY

*Shirley E. Foster*

HEALTH COMMISSIONER  
CITY OF GARY, IND.

DATE APR 25 1991