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PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS DOCUMENT NOT VALID. UNLESS STAMPED ON REVERSE SIDE

91022019

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Clyde L. Self, Sr.	2 SEX: Male	3a TIME OF DEATH: 4:15 P M	3b DATE OF DEATH (Month Day Yr): Sept. 16, 1990	
4 SOCIAL SECURITY NUMBER: 416-38-3219	5a AGE—Last Birthday (Years): 59 Yrs.	5b UNDER 1 YEAR (Months, Days)	5c UNDER 1 DAY (Hours, Minutes)	6 DATE OF BIRTH (Mo. Day, Yr): Jan. 1, 1931
7 BIRTHPLACE (City and State or Foreign Country): Gadsten, Alabama				
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1952	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): Pavillion Nursing Home	9c CITY, TOWN, OR LOCATION OF DEATH: Valparaiso	9d COUNTY OF DEATH: Porter		
10 MARITAL STATUS (Specify): Married	11 SURVIVING SPOUSE (If wife, give maiden name): Alberta Baer	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Roll Grinder	12b KIND OF BUSINESS/INDUSTRY: U.S. Steel Mill	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN, OR LOCATION: Lake Station	13d STREET AND NUMBER: 2929 New Hamshire St.	
13e ZIP CODE: 46405	13f INSIDE CITY LIMITS: ☐ No ☒ Yes; 13g ON A FARM? ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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) / College (1-4 or 5+): Unavailable				

PARENTS

18 FATHER'S NAME (First Middle Last): James E. Self	19 MOTHER'S NAME (First Middle Maiden Surname): Mary Massey

INFORMANT

20a INFORMANT'S NAME (Type/Print): Alberta Self	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2929 New Hampshire, Lake Station, IN	20c Relationship: Wife

tax mailing address

DISPOSITION

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): 9-19-90 Chapel Lawn Cemetery	21c LOCATION—City or Town, State: Schererville, IN
22a EMBALMER'S NAME: Roger A. Young	22b EMBALMER'S LICENSE NO.: FD08601323	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Roger A Young	24b LICENSE NUMBER (of Licensee): FD08601323	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Young Funeral Home-FH83001643 1307 Central Ave. Lake Station, IN

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cardiorespiratory Failure — Days

DUE TO (OR AS A CONSEQUENCE OF):

b. Astrocytoma Brain — Months

DUE TO (OR AS A CONSEQUENCE OF):

c. Congestive Heart Failure — Months

DUE TO (OR AS A CONSEQUENCE OF):

d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously noted in Part 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 OR CAUSE OF DEATH? (Yes or no)

FILED MAY 09 1991

[Recorder's stamp:] ROBERT ... RECORDER ... MAY 9 ... 1991 ... PM ... STATE OF INDIANA ... LAKE COUNTY ... FILED FOR RECORD ... 91 ... MAGS ... NO. 52 ...

[Seal:] RECORDER'S OFFICE SEAL INDIANA

[Stamp:] ... RECORDER LAKE COUNTY

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: Nallar M.D.	29c MEDICAL LICENSE NO.: 17329974	29d DATE SIGNED (Month, Day, Year): 9-18-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Surya Nallair, M.D. 6994 ... St Demotte, IN 46310

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD. — 32 DATE FILED (Month, Day, Year): September 20, 1990

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.		

6.00

Lloyd's Deep River Sub L.17 Bl.15

Key# 50-263-17; unit#35

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

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