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Local No. 699

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Aug 23 1990 Franklin D. Penuela M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MARVIN LEE MULLINS SR.
2. SEX: MALE
3a. TIME OF DEATH: 9:18 A M
3b. DATE OF DEATH (Month, Day, Yr): AUGUST 22, 1990
4. SOCIAL SECURITY NUMBER: 316-48-0311
5a. AGE—Last Birthday (Years): 43
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): OCTOBER 15, 1946
7. BIRTHPLACE (City and State or Foreign Country): GLEN, MISSIPPI
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NONE
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 30 BRUNSWICK
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): JUDY VALLE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): WINDOW CLEANER
12b. KIND OF BUSINESS/INDUSTRY: MAINTENANCE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 30 BRUNSWICK
13e. ZIP CODE: 46327
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): 6 — College (1-4 or 5+): 0

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIE LEE MULLINS
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE MAE CROUCH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JUDY MULLINS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 BRUNSWICK, HAMMOND, INDIANA 46327
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 25, 1990 Oakland Memory Lanes
21c. LOCATION—City or Town, State: Dolton, IL

22a. EMBALMER'S NAME: Robert Kincaid
22b. EMBALMER'S LICENSE NO.: IL 11088
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
24b. LICENSE NUMBER (of Licensee): 1051840
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Solan Funeral Home, Hammond, IN — Nowak Funeral Home, 400 Pulaski Rd., Calumet City, IL 60409

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

Approximate Interval Between Onset and Death

FILED
MAY 09 1991

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Renal Failure

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 OF CAUSE OF DEATH? (Yes or no)

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: Alan Jones DO
29c. MEDICAL LICENSE NO.: 640
29d. DATE SIGNED (Month, Day, Year): August 8-23-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Alan Jones D.O. 9128 Columbia, Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Penuela M.D.
32. DATE FILED (Month, Day, Year): AUG 23 1990

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 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.

North Side Add L.194 L.20 Bl.7
Key# 35-151-14, Un.1 #26

SBH08-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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