91022402

Local No. 748-88

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST: LAWRENCE MIDDLE: LAST: MARTIN

2 SEX: MALE

3 DATE OF DEATH (Mo. Day Yr.): MARCH 28, 1988

4 SOCIAL SECURITY NUMBER: 338-18-3313

5a AGE—Last Birthday (Years): 63

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Month, Day, Year): JULY 23, 1924

7 BIRTHPLACE (City and State or Foreign Country): HARRISBURG, ILLINOIS

8 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): THE COMMUNITY HOSPITAL

9c CITY, TOWN, OR LOCATION OF DEATH: MUNSTER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED

11 SURVIVING SPOUSE (If wife, give maiden name): MARGARET HUCKABAY

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ELECTRICIAN

12b KIND OF BUSINESS/INDUSTRY: CONTRACTOR

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN, OR LOCATION: MERRILLVILLE

13d STREET AND NUMBER: 5100 W. 73RD. AVE.

13e INSIDE CITY LIMITS? (Yes or no): YES

13f FARM: NO

13g ZIP CODE: 46410

14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:

15 RACE—American Indian, Black, White, etc. (Specify): WHITE

16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): CLAUDE MARTIN

18 MOTHER'S NAME (First, Middle, Maiden Surname): HELEN ROBERTSON

INFORMANT

19a INFORMANT'S NAME (Type/Print): MARGARET MARTIN

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5100 W. 73RD AVE, MERRILLVILLE, IN 46410

19c Relationship: WIFE

DISPOSITION

20a METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)

20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 3/29/88 MITCHELL FUNERAL HOME; 3/31/88 PURCELL CEMETERY, HIGHWAY 49,

20c LOCATION—City or Town, State: RECTOR, ARKANSAS; RURAL RECTOR, ARKANSAS

21a SIGNATURE OF FUNERAL DIRECTOR: Larry D. Anthony

21b LICENSE NUMBER (of Licensee): 1001447

22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ F.H. 3002916 9445 CALUMET AVE, MUNSTER, IN 46321

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title

23b LICENSE NUMBER

23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 7:07 P.M.

25 DATE PRONOUNCED DEAD (Month, Day, Year): MARCH 28, 1988

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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): Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: myocardial infarction; anasarca

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 (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: John Lanman

29c LICENSE NUMBER: 18203

29d DATE SIGNED (Month, Day, Year): 3/29/88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 716 Scherger Munster 46321 JOHN U. LANMAN, M.D.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [illegible signature]

32 DATE FILED (Month, Day, Year): 4-6-88

CORONER OR MEDICAL EXAMINER 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)

00695

600

Phillips 1st Add Lt 14

#11-135-14

FILED MAY 13 1991

I HEREBY CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ... ON FILE WITH THE LAKE COUNTY ... DEPT.

APR 6 1988

STATE OF INDIANA / S.S. NO. ... LAKE COUNTY ... RECORDER ... 10 AH '91