INDIANA STATE BOARD OF HEALTH

Local No. 90-0541 ... CERTIFICATE OF DEATH State No. 113-197

91022471

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Jeanella Laster
2. SEX	Female
3a. TIME OF DEATH	4:35 a.m.
3b. DATE OF DEATH (Month, Day, Yr.)	July 23, 1990
4. SOCIAL SECURITY NUMBER	307-41-5811
5a. AGE—Last Birthday (Years)	49
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo., Day, Yr.)	March 17, 1941
7. BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	No
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)	985 Clark Road
9c. CITY, TOWN, OR LOCATION OF DEATH	Gary
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Divorced
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	House Parent
12b. KIND OF BUSINESS/INDUSTRY	Lake County Association for the Retarded
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	985 Clark Road
13e. ZIP CODE	46404
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)	Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	College: 4years

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	William Harris
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Catherine (unknown)

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Yvette Laster
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	985 Clark Road Gary, Indiana 46404
20c. Relationship	daughter

DISPOSITION

Field	Entry
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)	July 28, 1990 Evergreen Cemetery
21c. LOCATION—City or Town, State	Hobart, Indiana
22a. EMBALMER'S NAME	Patrician Owens
22b. EMBALMER'S LICENSE NO.	#08700298
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Patricia O[signature]
24b. LICENSE NUMBER (of Licensee)	#08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue #83007704

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Mild cardiomegaly with a small right coronary ostium	Unknown
DUE TO (OR AS A CONSEQUENCE OF): b.	Moderate emphysematous changes of both lungs	
DUE TO (OR AS A CONSEQUENCE OF): c.	Hydrocephalus of lateral ventricle of brain with a	
DUE TO (OR AS A CONSEQUENCE OF): d.	cystic tumor at ventricle.	

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 stated in Part I.

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

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Daniel D Thomas [signature]
29c. MEDICAL LICENSE NO.	16120
29d. DATE SIGNED (Month, Day, Year)	July 25, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DANIEL D. THOMAS, M.D., CORONER, 2293 NORTH MAIN STREET, CROWN POINT, INDIANA 46307

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month, Day, Year)	JUL 30 1990

FILED

CORONER USE ONLY

Field	Entry
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)	July 23, 1990
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

4-30-91

Anne N. Anton

01539 600

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

Key #13-202-13- Sw. Cor. 1st Sub. Lot 14- Bl 6

Herbert R Bradley 2148 W 11th Ave Gary IN 46404-2306