

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 0802-91

91022473

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED—NAME (First, Middle, Last) Otis Thomas Marble				2. SEX Male	3a. TIME OF DEATH 12:55P	3b. DATE OF DEATH (Month, Day, Yr) April 9, 1991	
	4. SOCIAL SECURITY NUMBER 788-78-3507 609-75-9001		5a. AGE—Last Birthday (Years) 74	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) NOV 22, 1916		7. BIRTHPLACE (City and State or Foreign Country) Armored, Arkansas
DECEDENT	8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a. 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			
	9b. FACILITY NAME (If not institution, give street and number) Methodist Southlake				9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake	
PARENTS	10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Johnnie M. Leonard		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) warehouse man		12b. KIND OF BUSINESS/INDUSTRY Scot Lad Foods	
	13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 2133 Garfield Street	
INFORMANT	13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA		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, etc. (Specify) Afro Am	
	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (1-8) <input type="checkbox"/> Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		18. FATHER'S NAME (First, Middle, Last) Otis Thomas Marble		19. MOTHER'S NAME (First, Middle, Maiden Surname) Hutcherson			
DISPOSITION	20a. INFORMANT'S NAME (Type/Print) Johnnie M. Marble				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2133 Garfield Street, Gary, Indiana 46404		20c. Relationship Wife	
	21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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, funeral home, or other place) April 10, 1991 Evergreen Memorial		21c. LOCATION—City or Town, State Robart, Indiana			
CAUSE OF DEATH	22a. EMBALMER'S NAME Sherman G. Banks		22b. EMBALMER'S LICENSE NO. FDE1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
	24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ed W...</i>		24b. LICENSE NUMBER (of Licensee) FDO1042607		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH88900011 Smith Bizzell Warner & Son 4209 Grant St. Gary, In. 46408			
HEALTH OFFICER	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. a. Carcinoma of the Prostate with Metastases to Lungs and Bones b. Chronic Obstructive Pulmonary Disease c. Scurvy d. Electrolyte Imbalance with Renal Dysfunction							
	26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Diabetes Mellitus Type II							
CORONER USE ONLY	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) NO			
	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> MD		29c. MEDICAL LICENSE NO. 01029954		29d. DATE SIGNED (Month, Day, Year) 4-10-91	
CORONER USE ONLY	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. R. C. Gupta, 8300 Broadway, Merrillville, Indiana 46410							
	31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>					32. DATE FILED (Month, Day, Year) April 12, 1991		
CORONER USE ONLY	33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
	34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34d. DESCRIBE HOW INJURY OCCURRED					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						



FILED
MAY 13 1991

#47-207-40 - Wash. Rk. and N. 10' Lt 39 all Lt 40 Lt 41
 #47-207-40 - Wash. Rk. and N. 10' Lt 39 all Lt 40 Lt 41

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