91024460

Local No. 358

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.

May 8, 1991 — Date Issued — Franklin D. Ojemuda M.D. — Hammond Health Commissioner

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Mildred M. Schoonover
2. SEX	Female
3a. TIME OF DEATH	11:27 A
3b. DATE OF DEATH (Month, Day, Yr.)	May 5, 1991
4. SOCIAL SECURITY NUMBER	306-10-4415
5a. AGE—Last Birthday (Years)	70
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Feb.6, 1921
7. BIRTHPLACE (City and State or Foreign Country)	Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN?	no
8b. YEAR LAST SERVED IN US ARMED FORCES?	-----
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)	6932 Schneider Avenue
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)	John Schoonover
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Housewife
12b. KIND OF BUSINESS/INDUSTRY	Homemaker
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	6932 Schneider Ave.
13e. ZIP CODE	46323
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)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12 yrs
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	NA
19. MOTHER'S NAME (First, Middle, Maiden Surname)	NA

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	John Schoonover
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	6932 Schneider Ave. Hammond, Ind. 46323
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	May 8, 1991 Calumet Park Crematory
21c. LOCATION—City or Town, State	Merrillville, Ind.
22a. EMBALMER'S NAME	------
22b. EMBALMER'S LICENSE NO.	------
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Mary Solan
24b. LICENSE NUMBER (of Licensee)	FD 1004097
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Solan Funeral Home #3002893 7109 Calumet Ave., Hammond, Ind. 46324

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.	Vascular collapse	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF) b.	Due to arteriosclerotic heart and vascular disease	
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

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)	No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	

FILED MAY 22 1991

CERTIFIER

☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ MEDICAL EXAMINER / ☐ 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
29c. MEDICAL LICENSE NO.	16120
29d. DATE SIGNED (Month, Day, Year)	May 6, 1991
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 46407

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Franklin D. Ojemuda M.D.
32. DATE FILED (Month, Day, Year)	MAY 08 1991

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)	May 5, 1991
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

36-481- Wicker Hts.

60

863

STATE OF INDIANA, LAKE COUNTY, FILED FOR RECORD, MAY 22 10 ... 91, ROBERT ... RECORDER

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