L3815

91041428 INDIANA STATE BOARD OF HEALTH

Local No. 569-90

CERTIFICATE OF DEATH

State No.

COMMUNITY TITLE 60 Rec'd
421 W. 81st Avenue
Merrillville, IN 46410

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): HERMAN BRUSH
2. SEX: Male
3a. TIME OF DEATH: 5:25A M
3b. DATE OF DEATH (Month, Day, Yr): March 5, 1990
4. SOCIAL SECURITY NUMBER: 403-05-3455
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo, Day, Yr): JUL 31, 1916
7. BIRTHPLACE (City and State or Foreign Country): QUICKSAND, KENTUCKY
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): ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): ANNE CHEREPKO
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CRANE OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 3536 INDIANA STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): EDWARD BRUSH
19. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA TRUSTY

INFORMANT

20a. INFORMANT'S NAME (Type/Print): ANNE BRUSH
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3536 INDIANA STREET, HOBART, IN 46342
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): MAR 8, 1990 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FD01004194
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gerald Rees
24b. LICENSE NUMBER (of Licensee)
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FDH3003069 REES FUNERAL HOME, 600 WOODBRIDGE RD, HOBART, IN 46342

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
'91 AUG 15 AM 10 15
ROBERT ... COOPER-ZEELAND RECORDER

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

26. 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)
a. Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

PART II. Other significant conditions—Conditions contributing to death but not resulting in the underlying cause given in Part I.

27. WAS DECEDENT AUTOPSIED? (Yes or 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 AUG 1991
Anna M. Antich AUDITOR LAKE COUNTY

MAR 7 1990
Paul A. Johnson M.D. LAKE COUNTY HEALTH COMMISSIONER

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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: Richard Buyer M.D.
29c. MEDICAL LICENSE NO.: 25233
29d. DATE SIGNED (Month, Day, Year): March 7, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RICHARD BUYER M.D., 8895 BROADWAY, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A Johnson MD
32. DATE FILED (Month, Day, Year): MAR 7, 90

CORONER 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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

600 CM

50-287-49,50,52,53,54 199-a

Garden Nmo #5 Unit 1 Lts. 49 thru 54 #50-287 - 49 thru 54

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