

INDIANA STATE BOARD OF HEALTH

Local No. ... 1370-89 ...

CERTIFICATE OF DEATH

State No.

91041532

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

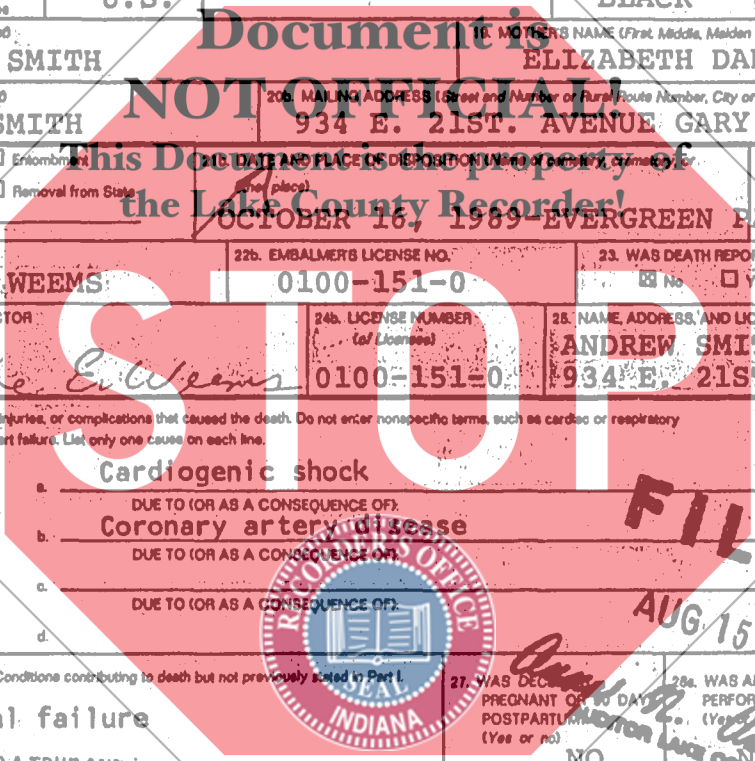
CORNER

HEALTH OFFICER

CORONER USE ONLY

Vertical handwritten notes on the left margin: #7-7881-1, #7-7881-2, #7-7881-3, #7-7881-4, #7-7881-5, #7-7881-6, #7-7881-7, #7-7881-8, #7-7881-9, #7-7881-10, #7-7881-11, #7-7881-12, #7-7881-13, #7-7881-14, #7-7881-15, #7-7881-16, #7-7881-17, #7-7881-18, #7-7881-19, #7-7881-20, #7-7881-21, #7-7881-22, #7-7881-23, #7-7881-24, #7-7881-25, #7-7881-26, #7-7881-27, #7-7881-28, #7-7881-29, #7-7881-30, #7-7881-31, #7-7881-32, #7-7881-33, #7-7881-34, #7-7881-35, #7-7881-36, #7-7881-37, #7-7881-38, #7-7881-39, #7-7881-40, #7-7881-41, #7-7881-42, #7-7881-43, #7-7881-44, #7-7881-45, #7-7881-46, #7-7881-47, #7-7881-48, #7-7881-49, #7-7881-50, #7-7881-51, #7-7881-52, #7-7881-53, #7-7881-54, #7-7881-55, #7-7881-56, #7-7881-57, #7-7881-58, #7-7881-59, #7-7881-60, #7-7881-61, #7-7881-62, #7-7881-63, #7-7881-64, #7-7881-65, #7-7881-66, #7-7881-67, #7-7881-68, #7-7881-69, #7-7881-70, #7-7881-71, #7-7881-72, #7-7881-73, #7-7881-74, #7-7881-75, #7-7881-76, #7-7881-77, #7-7881-78, #7-7881-79, #7-7881-80, #7-7881-81, #7-7881-82, #7-7881-83, #7-7881-84, #7-7881-85, #7-7881-86, #7-7881-87, #7-7881-88, #7-7881-89, #7-7881-90, #7-7881-91, #7-7881-92, #7-7881-93, #7-7881-94, #7-7881-95, #7-7881-96, #7-7881-97, #7-7881-98, #7-7881-99, #7-7881-100.

Main form containing fields for: 1. DECEASED—NAME (First, Middle, Last) ANDREW SMITH SR.; 2. SEX MALE; 3a. TIME OF DEATH 10:35 P; 3b. DATE OF DEATH (Month, Day, Year) OCTOBER 10, 1989; 4. SOCIAL SECURITY NUMBER 192-18-7431; 5a. AGE—Last Birthday (Years) 61; 5b. UNDER 1 YEAR Months Days; 5c. UNDER 1 DAY Hours Minutes; 6. DATE OF BIRTH (Mo, Day, Yr) MAY 30, 1928; 7. BIRTHPLACE (City and State or Foreign Country) PIPECREEK, OHIO; 8a. WAS DECEDENT A U.S. VETERAN? NO; 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---; 8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: Inpatient; 9b. FACILITY NAME (If not institution, give street and number) HOBART 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) PEARL M. HENDERSON; 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SELF-EMPLOYED; 12b. KIND OF BUSINESS/INDUSTRY FUNERAL DIRECTOR; 13a. RESIDENCE—STATE INDIANA; 13b. COUNTY LAKE; 13c. CITY, TOWN, OR LOCATION GARY; 13d. STREET AND NUMBER 934 E. 21ST AVENUE; 13e. ZIP CODE 46407; 14. CITIZEN OF WHAT COUNTRY? U.S.; 15. WAS DECEDENT OF HISPANIC ORIGIN? No; 16. RACE—American Indian, Black, White, etc. (Specify) BLACK; 17. DECEDENT'S EDUCATION (Specify) College (1-4); 18. FATHER'S NAME (First, Middle, Last) JOSEPH SMITH; 19. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH DANIELS; 20a. INFORMANT'S NAME (Type/Print) PEARL M. SMITH; 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 E. 21ST AVENUE GARY, IN. 46407; 20c. Relationship WIFE; 21a. METHOD OF DISPOSITION (Check one) Burial; 21b. LOCATION—City or Town, State HOBART, INDIANA; 22a. EMBALMER'S NAME DIANE E. WEEMS; 22b. EMBALMER'S LICENSE NO. 0100-151-0; 23. WAS DEATH REPORTED TO CORONER? No; 24a. SIGNATURE OF FUNERAL DIRECTOR; 24b. LICENSE NUMBER (of Licensee) 0100-151-0; 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANDREW SMITH FUNERAL HOME 934 E. 21ST AVENUE-83002550; 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiogenic shock; b. Coronary artery disease; c. Sepsis, renal failure; 27. WAS DECEDENT PREGNANT OR POSTPARTUM? NO; 28a. WAS AN AUTOPSY PERFORMED? NO; 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO; 29b. MEDICAL LICENSE NO. 01035204; 29d. DATE SIGNED (Month, Day, Year) 10-18-89; 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Eric Schulte, M.D. 7863 Broadway, Merrillville, IN 46410; 31. HEALTH OFFICER'S SIGNATURE; 32. DATE FILED (Month, Day, Year) Oct. 19, 1989; 33. MANNER OF DEATH; 34a. DATE OF INJURY; 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) # yes, specify driver, passenger, pedestrian, etc.



FILED AUG 15 1991

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