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INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 407 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME - (First, Middle, Last) EDWARD H. CAMPBELL		2 SEX MALE	3a TIME OF DEATH 1:30P M	3b DATE OF DEATH (Month, Day, Yr.) DECEMBER 31, 1989	
4 SOCIAL SECURITY NUMBER 360-20-5084	5a AGE—Last Birthday (Years) 60	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr.) SEP. 21, 1929	7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS
8a WAS DECEDENT A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMED FORCES? 1946-1948	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA	OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence		
9b FACILITY NAME (If not institution, give street and number) ST. CATHERINE HOSPITAL		9c CITY, TOWN, OR LOCATION OF DEATH EAST CHICAGO	9d COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) PATRICIA BURKE	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ELECTRICIAN	12b KIND OF BUSINESS/INDUSTRY LTV STEEL		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN, OR LOCATION HIGHLAND	13d STREET AND NUMBER 8436 GORDON DRIVE		
13e ZIP CODE 46322	13f INSIDE CITY LIMITS [ ] No [ ] Yes	13g ON A FARM? [X] No [ ] Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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) 11yrs	College (1-4 or 5+)				
18. FATHER'S NAME (First, Middle, Last) EDWARD H. CAMPBELL		19. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE NOVAK			
20a. INFORMANT'S NAME (Type/Print) PATRICIA CAMPBELL	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8436 GORDON DR HIGHLAND INDIANA	20c. Relationship WIFE			
21a. METHOD OF DISPOSITION [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) JANUARY 4, 1989 ELMWOOD CEMETERY	21c. LOCATION—City or Town, State HAMMOND, INDIANA			
22a. EMBALMER'S NAME JAMES E. PORRAS	22b. EMBALMER'S LICENSE NO 1045964	23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR [signature]	24b. LICENSE NUMBER (of Licensee) 1021590	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS-KISH FUNERAL HOME 3004968 8415 CALUMET AVE MUNSTER, INDIANA			

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. CARDIORESPIRATORY ARREST	24 Hours
	DUE TO (OR AS A CONSEQUENCE OF) b. ACUTE MYELOMONOBLASTIC LEUKEMIA	1 week
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c. MYELODYSPLASIA WITH PANCYTOPENIA	3 yrs
	DUE TO (OR AS A CONSEQUENCE OF) d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

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

29a. CERTIFIER (Check only one)
[X] 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
[signature]	0103158 2	1-5-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
DR. LYLE MUNN 4321 FIR EAST CHICAGO INDIANA 46312

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
E. A. Campagna M.D.	1-9-90

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				
	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.			

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