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Key#41-110-28, 29430
Broadhurst
4,28,29430 BL3

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1902-91 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last) HAROLD T. LANKFORD			2. SEX MALE	3a. TIME OF DEATH 7:45P.	3b. DATE OF DEATH (Month, Day, Yr) September 14, 1991
4. SOCIAL SECURITY NUMBER 316-22-8307	5a. AGE—Last Birthday (Years) 62	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo, Day, Yr) DEC. 21, 1928	7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. 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) Methodist Hospital Southlake Campus		9c. CITY, TOWN OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Virginia Hile	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright		12b. KIND OF BUSINESS/INDUSTRY Construction	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary		13d. STREET AND NUMBER 4936 Pennsylvania Street	
13e. ZIP CODE 46409	13f. INSIDE CITY LIMITS? ☐ No ☒ Yes	13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) Thomas Lee Lankford	19. MOTHER'S NAME (First, Middle, Maiden Surname) Eileen Thelma Myers

INFORMANT

20a. INFORMANT'S NAME (Type/Print) Virginia Lankford	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4936 Pennsylvania St., Gary, Indiana 46409	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) September 18, 1991 Chapel Lawn Memorial Gardens	21c. LOCATION—City or Town, State Schererville, Indiana	
22a. EMBALMER'S NAME: Alexis Thanos	22b. EMBALMER'S LICENSE NO. FD08600505	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR Alexis Thanos	24b. LICENSE NUMBER (of Licensee) FD08600505	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, INC., FH83007762 7905 Broadway, Merrillville, IN 46410	

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Hepatic Failure

DUE TO (OR AS A CONSEQUENCE OF): b. Anoxic Encephalopathy

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF):

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

Approximate Interval Between Onset and Death

FILED SEP 30 1991 JAN 9 1992

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

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

Dana N. Antos
AUDITOR LAKE COUNTY

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
MD	50002600	9-16-91

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Peter Mavrelis, 8895 Broadway, Merrillville, Indiana 46410

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.

32. DATE FILED (Month, Day, Year): September 17, 1991

CORONER USE ONLY

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)

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

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