

TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

92002719

Local No.

784-85

INDIANA STATE BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

State  
No.

Below for State Office Use

A Key# 27-32-21  
B N. 50 FT. OF S. 24 FT.  
C OF E. 180 FT. OF SE 1/4  
D NW 1/4 SE 1/4  
E S. 22 T. 36 R. 9  
F 12.05 Ac.

FUNERAL HOME  
No. 750

FUNERAL DIRECTOR'S  
LICENSE No. 94

APR 24 1985

FUNERAL DIRECTOR'S  
SIGNATURE

TYPE OR PRINT  
IN  
PERMANENT  
INK  
FOR  
INSTRUCTIONS  
SEE  
HANDBOOK

DECEASED

USUAL RESIDENCE  
WHERE DECEASED  
LIVED, IF DEATH  
OCCURRED IN  
INSTITUTION, GIVE  
RESIDENCE BEFORE  
ADMISSION

PARENTS

DISPOSITION

*Charles Johnson*  
LAKE COUNTY HEALTH COMMISSIONER

CONDITIONS  
IF ANY  
WHICH GAVE  
RISE TO  
IMMEDIATE  
CAUSE;  
STATING THE  
UNDERLYING  
CAUSE LAST

CAUSE

DECEASED - NAME 1 <b>Grover C. McClellan</b>			SEX 2 <b>Male</b>		DATE OF DEATH - MONTH DAY YEAR 3 <b>April 23, 1985</b>	
RACE - (eg. White, Black, American Indian, etc.) 4 <b>White</b>		AGE - Last Birthday (Year) 5a <b>61</b>		DATE OF BIRTH - MONTH DAY YEAR 6 <b>Jan. 23, 1924</b>		COUNTY OF DEATH 7a <b>Lake</b>
CITY, TOWN OR LOCATION OF DEATH 7b <b>Crown Point</b>			HOSPITAL OR OTHER INSTITUTION 7c <b>St. Anthony Hospital</b>			IF HOSP OR INST. INPATIENT FOR 14 7d <b>Inpatient</b>
STATE OF BIRTH - (If not in U.S. name country) 8 <b>Indiana</b>		CITIZEN OF WHAT COUNTRY 9 <b>U.S.A.</b>		MARRIED, NEVER MARRIED, WIDDED, DIVORCED (Specify) 10 <b>Married</b>		SURVIVING SPOUSE - (If not give name and address) 11 <b>Lois Underwood</b>
SOCIAL SECURITY NUMBER 12 <b>314-14-4187</b>			USUAL OCCUPATION - (If not state kind of work done during most of working life specify in detail) 13 <b>Millwright</b>			KIND OF BUSINESS OR INDUSTRY 14 <b>Steel</b>
RESIDENCE - STATE 15a <b>Indiana</b>		CITY, TOWN OR LOCATION 15b <b>Medaryville</b>		IS RESIDENCE ON A FARM? 15c <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INSIDE CITY LIMITS? (Specify Yes or No) 15d <b>Yes</b>
IS DECEASED OF SPANISH DESCENT? (If YES specify MEXICAN, CUBAN, PUERTO RICAN, ETC.) 16 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
FATHER - NAME 17a <b>Grover C. McClellan</b>			MOTHER - MAIDEN NAME 17b <b>Anna Haven</b>			
INFORMANT - NAME (Type or print) 18a <b>Lois McClellan</b>			RELATIONSHIP 18b <b>Wife</b>		MAILING ADDRESS - (Street or R.F.D. No., City or Town, State, ZIP) 18c <b>Box 210 Medaryville, Indiana</b>	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a <b>Cremation</b>			CEMETERY OR CREMATORY - FUNERAL HOME 19b <b>Oakland Memory Lane</b>		LOCATION - (City or Town, State, ZIP) 19c <b>Dolton, Illinois</b>	
DATE - (Month, Day, Year) 20a <b>April 25, 1985</b>			FUNERAL HOME - NAME AND ADDRESS 20b <b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, IN 46322</b>			
21a Signature: <i>Paul J. Johnson</i>					DATE SIGNED (Month, Day, Year) <b>JAN 14 1992</b>	
21b NAME OF ATTENDING PHYSICIAN (Type or print) <i>Paul J. Johnson</i>					HOUR OF DEATH 21c <b>11</b>	
21d MAILING ADDRESS - PHYSICIAN					DATE RECEIVED BY LOCAL HEALTH OFFICER <b>APR 24 - 85</b>	
21e HEALTH OFFICER - SIGNATURE: <i>Charles Johnson</i>					21f	
22 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR USE IN PART I) PART I (a) <b>Respiratory Arrest</b>						
DU TO OR AS A CONSEQUENCE OF						
(b) <b>Amyotrophic lateral Sclerosis</b>						
DU TO OR AS A CONSEQUENCE OF						
PART II (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a)						
PART II (d) AUTOPSY (Specify Yes or No) 24						

SBH 06-003 State Form 35430  
REV. 10/77

*Penkerton + Friedman*  
77 9008 Judges Bluff  
Highland IN 46322

*W.C.*

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

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