INDIANA STATE BOARD OF HEALTH

| Local No: | 58:88peoug | 49 3 | CERTIFICAT | E OF DEATH | State | No | | |
|---------------------------------------|--|---|--|--|--|---|---|--|
| TYPE/PRINT | 1 DECEASED—NAME FIRST | | DOLE | LAST | | | OF DEATH (Me Dey Yr) | |
| IN PERMANENT | WILLI 4 SOCIAL SECURITY NUMBER 5 | ACE-Last Birthday | H. SO UNDER I YEAR | TWILLA, JR. | | MALE JANU | ARY 6, 1988 ng Siate or Foreign Country) | |
| | 409-40-1229 | 57 | Months Days | Hours Minutes | | | , TENNESSEE | |
| | 8 YEAR LAST SERVED IN US ARMED FORCES? | 9a PLACE OF DEATH (Check only one See namethon ant ER/Outpatient OOA OTHER Nursing Home Residen | | | | | | |
| # DECEDENT | 1953 96 FACILITY NAME (If not institution give at | 9c CITY, TOWN OR LOCATION OF DEATH | | | | | | |
| | BROADWAY METHODIST SOUTHLAK | | | | | INA LAKE | | |
| | Never Married Widowed. (If wife, give m | | (Give kind of work done during most of | | DCCUPATION during most of working ide | EAST GARY | | |
| | MARRIED' | LOUISE CAR | CARSON OWNER | | ATOR 130 STREET AND N | | INSULATION COMPANY | |
| | l 1 | ORTER | PORTAGE | | | UNRISE | | |
| | 13e INSIDE CITY 13f. FARM LIMITS? (Yes or no) | 13g ZIP CODE | (Specify No or Ye | OF HISPANIC ORIGIN? s - # yes spęcety Cuben | 15 RACE—American Indian Black White etc | | DENT'S EDUCATION highest grade completed) | |
| | YES NO | 46368 | Mexican, Puerto R Specify | can etc) 🗴 No 🗀 Yei | (Specify) WHITE | Elementary/Secondary | (0-12) Callege (1-4 or 5 +) | |
| PARENTS | 17 FATHER'S NAME (First Middle, Last) | A CD 1 | | | ERS NAME (First Middle Maider | Surnama) | | |
| INITIATIVANIT | WILLIAM H. TWILL 198 INFORMANTS NAME (Type/Print) | A, SR. | OCUM 196 MAILING | | MAY SMITH | r Town State, Zip Codel | 19c Relationship | |
| INFORMANT | LOUISE TWILLA | NO | 6132 | SUNRISE, PO | RTAGE, INDIAN | A 46368 | WIFE | |
| | 20e METHOD OF DISPOSITION Burial Cremation Reg | soval from State | 206 DATE AND PLACE other place) | OF DISPOSITION (Name of | comotory, cramatory or | 20c LOCATION—City of | r Town, State | |
| DISPOSITION 3 | □ Donation □ Other (Specify) □ | his Doc u | | P P | RCREEN CEMETE | | | |
| 3 3 | 21. SIGNATURE OF FUNERAL DIRECTOR | the Lal | ke Count | CENSE NUMBER WKONSE COTO | PIREES FUNERA | HOME, OLS | HALHOMEDH300561: SON CHAPEL | |
| Danna Maine | James L. | Maus | e FDE | 1006463 | 5341 CENTRA | L AVE., POR | RTAGE, IN 4636 | |
| PRONOUNCING PHYSICIAN ON | Complete items 23a-c only when certifying physician is not available at time of death | To the best of my know | ledge, deeth occurred at 1 | ne time, date, and place stated. | | ISE NUMBER | 23c. DATE SIGNED (Month Day, Year) | |
| ITEMS 24-26 MUST THE BE COMMPLETED BY | to certify cause of death Sign | nature and Title < | 4 / 5 / / | yaya ory | | SC ₹ | 118188. | |
| PERSON WHO PRONOUNCES DEAD | Le Time Or Bearing | JANUARY 6, | | | 26 WAS (| CASE REFERRED TO MEDIC Proposition NO | CAL EXAMINER/CORONER? | |
| 7 | 27/PART I. Enter the diseases injurie | s, or complications that ca | sused the death. Do not an | ter the mode of dying, such at | cardiac or respiratory | | Approximate | |
| * + | errest, shock, or heart faul | ure List only one cause o | n each line. | | | | Interval Between Onset and Oseth | |
| ٠٤ Ý | disease or condition resulting in death) | DUE TO | OR AS A CONSECUTIVE | CE DFI | re of | | - Com | |
| SEE INSTRUCTIONS | Sequentially list conditions. | · Slike | - Contraction | L. Ke | my de | lege | 4 year | |
| . i. | If any, leading to immedial cause Enter UNDERLYING CAUSE (Disease or injury | OUE TO (| CA STATE OF THE PROPERTY OF TH | | | | | |
| 27 | that initiated events resulting in death) LAST | Sent Due 10 (| OR AS A CONSEQUENC | EOF) | | | | |
| CAUSE OF 79 | | d. Ing to death, but not result | ing in the underlying caus | e gryeg in Peni). | , 28aWAS | AN AUTOPSY 28b | WERE AUTOPSY FINDINGS | |
| | JAN | 1992 | | | | ORMED? C AVAILABLE PATOR TO COMPLETION OF CAUSE | | |
| , (5) | A. m | 0 | | line | NO | 132 | DF DEATH? (Yes or no) | |
| B 1- | 29. CERTIFIER ALLEGICENTE YEAR | O PHYSICIAN (Physician | n carplying cause of death | when another physician has t | pronounced death and completed | 20 | 31 PM | |
| & SEE € INSTRUCTIONS | (Check only one) To the best | of my knowledge, death | occurred due to the cause | (s) and manner as stated | | | | |
| 4 1 | | | | ooth pronouncing death and ca and place, and due to the cau | | ω | | |
| | ☐ MEDICAL | ····· | ., | *************************************** | | 717 | | |
| | On the bea | s of examination and/or ii | nvestigation, in my opinion | death occurred at the time, d | ate, and place, and due to the cau | sets) end manner sa feeting | <u> </u> | |
| | 296 SIGNATURE AND TITLE OF OTH FIFEE | | £ | MO. | ,290 LICENSE NUMBE | L-1 . | TE SIGNED (Month Day, Year) | |
| 3 10 | 30 NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH (ITEM 27) (7 | | 0029/6 | 6 | -12-38 | |
| 7. | HAKAM SAFADI, MD | | | | LVILLE, INDIA | NA 46410 | | |
| . HEALTH | HEALTH OFFICERS SIGNATURE JOHNSON STORE STOR | | | | | | TE FILED (Month Day, Year) | |
| OFFICER 6 | 33. MANNER OF DEATH | 340 DATE OF INJUI | NY JAB TIME OF | 34c. INJURY AT W | DRK7 34d DESCRIBE H | OW INJURY OCCURRED | 11/12/80 | |
| CORONER OR | ☐ Natural ☐ Panding | (Month, Day, Ya | YRULNI (| (Yes or no) | | | | |
| MEDICAL EXAMINER USE | Accident Investigation Suicide Could not be | 344 IN ACE OF INTE | URY—At home, farm, stre | et fantony office | TALL DOCATION (Second 2015) | umber or Dural Decemble | M Chia Tara Sana | |
| ONLY | Homocide Determined | building, etc. (Sp | | ec rectory, orne | 34F LOCATION (Street and N | umurer or nurel house Numb | w. Cny or lown. State) | |
| | S8H06-004 State Form 10110 (F | 7/10-87) DEATH | A/PD 1 | | /) . | 0162 | 1 . U'' | |
| ja | is Juneal 1 | Home 6 | :00W K | idge Ho | bart 463 | 42 | | |