92008806

Local No. 0264-92

Toryville Add L17 Key #-19-60-19 Unit # 27

2 Rush 2 Vet 100 total

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): EUGENE J. PARENT
2. SEX: Male
3a. TIME OF DEATH: 6:50PM
3b. DATE OF DEATH (Month, Day, Yr): February 1, 1992
4. SOCIAL SECURITY NUMBER: 312-18-7571
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): JUL 23, 1924
7. BIRTHPLACE (City and State or Foreign Country): YOUNGSTOWN, OHIO
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
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. 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): HELEN M. KIMBERLY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HEAVY EQUIPMENT OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: LOCAL 150
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HOBART
13d. STREET AND NUMBER: 812 GARFIELD STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM? [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): PETER PARENT
19. MOTHER'S NAME (First, Middle, Maiden Surname): PHYLLIS POLITE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): HELEN M. PARENT
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 GARFIELD ST., HOBART, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial [X] Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB 4, 1992 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FD01004194
23. WAS DEATH REPORTED TO CORONER? [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

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 or heart failure. List only one cause on each line.

COMPLETE COPY OF DEATH ON FILE WITH THE LAKE COUNTY

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Respiratory failure	1 day
DUE TO (OR AS A CONSEQUENCE OF)	Cor pulmonale	1 wk
DUE TO (OR AS A CONSEQUENCE OF)	Severe Emphysema	10 yrs.
DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. FEB 04 1992

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

LAKE COUNTY HEALTH COMMISSIONER

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

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: (signature)
29c. MEDICAL LICENSE NO.: 01030518
29d. DATE SIGNED (Month, Day, Year): 2-3-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SOMPOP SRISUWANANUKORN MD, 8695 CONNECTICUT STREET, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
FILED
32. DATE FILED (Month, Day, Year): February 4, 1992

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): FEB 11 1992
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): Oscar N. Anton AUDITOR LAKE COUNTY 600
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

00539

SBH06-004 State Form 10110 (R2/3-89)

Rees Funeral Home 600 W Ridge Rd Hobart 46342