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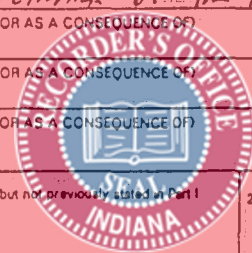
INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Homeskood Gardens
Mortg. Add. N. 1, B. 7
State No. ... Key # 37-37-1...
Unit # 16

Local No. 2644-90

TYPE/PRINT
IN:
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Elva G. Carroll		2 SEX Female	3a TIME OF DEATH 7:00 P.M.	3b DATE OF DEATH (Month Day Year) December 31, 1990
4 SOCIAL SECURITY NUMBER 159-12-3990	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Mar. 21, 1919
7 BIRTH PLACE (City and State or Foreign Country) Pittsburgh, PA.	8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> FR. Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)
9b FACILITY NAME (If not institution, give street and number) 3203 Eder St.	9c CITY TOWN OR LOCATION OF DEATH Highland	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) John Carroll	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home-Maker	12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Highland	13d STREET AND NUMBER 3203 Eder St.	
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION: (Specify fairly highest grade completed) Elementary/Secondary (10-12) College (1-4 or 5 +) 12	18 FATHER'S NAME (First Middle Last) Edward Vollmer			
19 MOTHER'S NAME (First Middle Maiden Surname) Gertrude Rouse		20a INFORMANT'S NAME (Type/Print) John Carroll		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3203 Eder St. Highland, Indiana		20c Relationship Husband		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from Site <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 3, 1991 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Edgar Gleim	22b EMBALMER'S LICENSE NO. FDO 1016173	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b LICENSE NUMBER (of Licensee) FDO 1014511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500		
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): Conditions, if any, which gave rise to the immediate cause stating the underlying cause last 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) NO		
28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 <i>[Signature]</i>		
29c MEDICAL LICENSE NO. 33507		29d DATE SIGNED (Month, Day, Year) 1-2-91		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) HOWARD M. MISHOULAM, M.D., 9725 PRAIRIE AVENUE, HIGHLAND, IN 46322				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) JAN 3 1991
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) FEB 14 1992	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 600		34e 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, etc.) AUDITOR LAKE COUNTY		



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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