92010194

Pt W1/2 S1/2 SW S.33 T.35 R.8
Key# 23-7-5, unit# 33

Local No. 47391-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Noel E. Sprout
2. SEX: Male
3a. TIME OF DEATH: 4:45 PM
3b. DATE OF DEATH (Month, Day, Yr.): December 4, 1989
4. SOCIAL SECURITY NUMBER: 305-09-3714
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): February 15, 1913
7. BIRTHPLACE (City and State or Foreign Country): Janesville, Wisc.
8a. WAS DECEDENT A US VETERAN?: None
8b. YEAR LAST SERVED IN US 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): Doris Coerper
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Transportation Exec.
12b. KIND OF BUSINESS/INDUSTRY: Trucking
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 9915 Merrillville Rd.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): / College (1-4 or 5+): 5

PARENTS

18. FATHER'S NAME (First, Middle, Last): Mortimer Guy Sprout
19. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel May Balsley

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Doris Sprout
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9915 Merrillville Rd. Crown Point, IN
20c. Relationship: wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 7, 1989 Winconsin Memorial Park
21c. LOCATION—City or Town, State: Brookfield, Wisconsin
22a. EMBALMER'S NAME: Barry B. Little
22b. EMBALMER'S LICENSE NO: FD01022326
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Barry B. Little
24b. LICENSE NUMBER (of Licensee): FD01022326
25. NAME AND ADDRESS OF FACILITY: Little Funeral Service, 811 E. Franciscan Dr., Crown Point, IN 46307 FH83001261

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. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: Few Minutes
DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease — 50+ Years
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

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.: COPD — Rheumatic Heart Disease
27. WAS DECEDENT PREGNANT OR 60 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)

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: Dennis F. Carpenter MD
29c. MEDICAL LICENSE NO.: 19528
29d. DATE SIGNED (Month, Day, Year): 12-5-89

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dennis F. Carpenter M.D — 123 N. Court — Crown Point Ind. 46307
31. HEALTH OFFICER'S SIGNATURE: Carl A Johnson
FILED
32. DATE FILED (Month, Day, Year): Dec. 6, 1989

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 Ooccurred: FEB 19 1992
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): Lake N. Aston
LAKE COUNTY
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver:
927

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