92011237 ~~[illegible]~~-89

Local No. ....

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Hold – Bette x3535 [illegible]

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): SAMUEL TODD	2. SEX: MALE	3a. TIME OF DEATH: 6:20P M	3b. DATE OF DEATH (Mo. Day, Yr.): DECEMBER 20, 1989
4. SOCIAL SECURITY NUMBER: 306-09-3915	5a. AGE—Last Birthday (Years): 73	5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes):	6. DATE OF BIRTH (Mo. Day, Yr.): MAY 22, 1916
7. BIRTHPLACE (City and State or Foreign Country): BISMARCK, MISSOURI	8a. WAS DECEDENT A U.S. VETERAN?: YES	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: WW II	9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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 COUNTY	
10. MARITAL STATUS (Specify): MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name): WILLIE R. SMITH	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STEELWORKER	12b. KIND OF BUSINESS/INDUSTRY: US STEEL/BETHLEHEM STEEL
13a. RESIDENCE—STATE: INDIANA	13b. COUNTY: LAKE	13c. CITY, TOWN, OR LOCATION: MERRILLVILLE	13d. STREET AND NUMBER: 475 EAST 60TH PLACE
13e. ZIP CODE: 46410	13f. INSIDE CITY LIMITS: ☐ No XX Yes; 13g. ON A FARM?: XX No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): [illegible] College (1-4 or 5+):		

PARENTS

18. FATHER'S NAME (First, Middle, Last): GEORGE SILAS TODD, SR.

19. MOTHER'S NAME (First, Middle, Maiden Surname): MAUDE ELIZABETH (THOMASSON) SIMMS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): WILLIE TODD

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 475 EAST 60TH PL, MERRILLVILLE, IN 46410

20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 23, 1989 CALUMET PARK CEMETERY

21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA

22a. EMBALMER'S NAME: JAMES W. GHOLSTON

22b. EMBALMER'S LICENSE NO.: FD01004194

23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b. LICENSE NUMBER (of Licensee): F[illegible]04[illegible]3

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOMES, INC. FDH3003069 600 WEST 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, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):
b. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):
c. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

FILED FEB 25 1992

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

DEC 27 1989

LAKE COUNTY HEALTH [illegible] ...ONER

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): N/A

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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: R. H. Hovanessian [illegible]

29c. MEDICAL LICENSE NO.: 01017353

29d. DATE SIGNED (Month, Day, Year): 12/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RAFFY HOVANESSIAN, MD, 7863 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:

32. DATE FILED (Month, Day, Year):

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 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):

34g. DATE PRONOUNCED DEAD (Month, Day, Year):

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

15-509-59 Old Airport Add. Pa. 23 &

600

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

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