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INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Fashion Terrace Unit 1, lot 8
Ve, #9-152-8

Local No. C4129-92

State No. Unit #33

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): HOWARD D. OAKES
2. SEX: MALE
3a. TIME OF DEATH: 5:30A.M.
3b. DATE OF DEATH (Month Day Yr): FEBRUARY 20, 1992
4. SOCIAL SECURITY NUMBER: 317-09-9201
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): JULY 27, 1908
7. BIRTHPLACE (City and State or Foreign Country): KANKAKEE, ILLINOIS
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 [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MARY KUSAK
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FOREMAN
12b. KIND OF BUSINESS/INDUSTRY: ANDERSON COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 139 CHASE DRIVE
13e. ZIP CODE: 46307
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): N/A; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): SAMUEL OAKES
19. MOTHER'S NAME (First, Middle, Maiden Surname): SUSAN HILLS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARY OAKES
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 139 CHASE DR., CROWN POINT, IN46307
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 22, 1992 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO.: 1010711
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME, 10101 BROADWAY CROWN POINT, IN46307 FDH83002445

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 handwriting]
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)

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)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED
FEB 21 1992
[Stamp:] AUDITOR LAKE COUNTY

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

FEB 21 1992

CERTIFIER

29a. CERTIFIER (Check only one): [X] 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] MD
29c. MEDICAL LICENSE NO.: [illegible]
29d. DATE SIGNED (Month, Day, Year): 2/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A. Kittari St. Anthony Med Center

HEALTH OFFICER

31. HEALTH OFFICER SIGNATURE: Alexander S. Williams, M.D. [illegible]
32. DATE FILED (Month, Day, Year): February 21, 1992

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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.

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

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