

Shirley A. Combs
Sudder, NW S. 29 T. 37 R. 9
Lot 31, Bl. 13
K/2, 30-61-32

92013691

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ... 1001424

Local No. 1986-90

TYPE/PRINT
IN
PERMANENT
BLACK-INK

1 DECEASED NAME (First Middle Last) MARGARET E. TOMPKINS		2 SEX FEMALE	3 TIME OF DEATH 7:05 P.M.	4 DATE OF DEATH SEPTEMBER 29, 1990
5 SOCIAL SECURITY NUMBER 398-07-7459	6a AGE Last Birthday (Years) 72	6b UNDER 1 YEAR Months Days	6c UNDER 1 DAY Hours Minutes	7 DATE OF BIRTH (Month Day Year) April 1, 1918
8a WAS DECEASED A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? -	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> N/A OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9c CITY/TOWN OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Walter Tompkins	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of week. Do not use "retired.") Assembly Line Feeder	12b EMPLOYER BUSINESS INDUSTRY Pepsi-Cola Co.	
13a RESIDENT STATE Indiana	13b COUNTY Lake	13c CITY/TOWN OR LOCATION East Chicago	13d STREET AND NUMBER 1106 W. 144th Street	
13e ZIP CODE 46312	14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE American Indian Black White etc. (Specify) White
17 ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	18 FATHER'S NAME (First Middle Last) Peter Erickson		19 MOTHER'S NAME (First Middle Maiden Surname) Anna Ray	
20a INFORMANT'S NAME (Type-Print) Walter Tompkins		20b MARITAL ADDRESS (Street and Street or Rural Route Number, City or Town, State, ZIP Code) East Chicago, IN 46312		20c Relationship husband
21a MANNER OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Burial from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Specify cemetery, or other place) October 3, 1990 Chapel Lawn Memorial Gardens		21c LOCATION - City or Town, State Schererville, Indiana
22a FUNERAL HOME NAME Woodrow W. Donovan		22b FUNERAL HOME LICENSE NO. FD01053135	23 WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>John P. Lipe</i>		24b LICENSE NUMBER (of License) FD01020366	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls. Blvd. East Chicago, IND	
26 PART I - Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as "cause of respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (final disease or condition resulting in death): a. Medication - Ruled Civil Coroner's Day b. DUE TO ILLNESS AS A CONSEQUENCE OF c. DUE TO ILLNESS AS A CONSEQUENCE OF d. DUE TO ILLNESS AS A CONSEQUENCE OF				
27 PART II - Other significant conditions - Conditions contributing to death but not previously stated in Part I. 27a WAS DECEASED IN CHAIN OR 90 DAYS POSTMORTEM? (Yes or no) NO 27b WAS AN AUTOPSY PERFORMED? (Yes or no) NO 27c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO				
28a 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.				
28b SIGNATURE AND TITLE OF CERTIFIER <i>M. Y. Ali M.D.</i>		28c MEDICAL LICENSE NO. 29782	28d DATE SIGNED (Month Day Year) SEPTEMBER 30, 1990	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 20) (Type-Print) DR. MOHAMMAD Y. ALI M.D. 9116 COLUMBIA AVENUE, MUNSTER, INDIANA 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Paul Johnson</i>				
32 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined.				
33a DATE OF DEATH (Month Day Year)		33b TIME OF DEATH	33c DEATH CERTIFICATE NUMBER	
34a PLACE OF DEATH (At home, farm, street, factory, office, building, etc. (Specify))		34b MOTOR VEHICLE ACCIDENT? (Yes or no) NO		
34c DATE PROHOUNCED DEAD (Month Day Year)		34d MOTOR VEHICLE ACCIDENT? (Yes or no) NO		

DECEDENT

PARENTS

INFORMANT

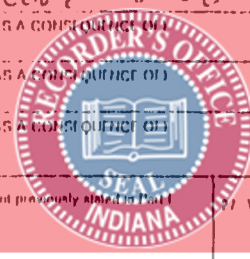
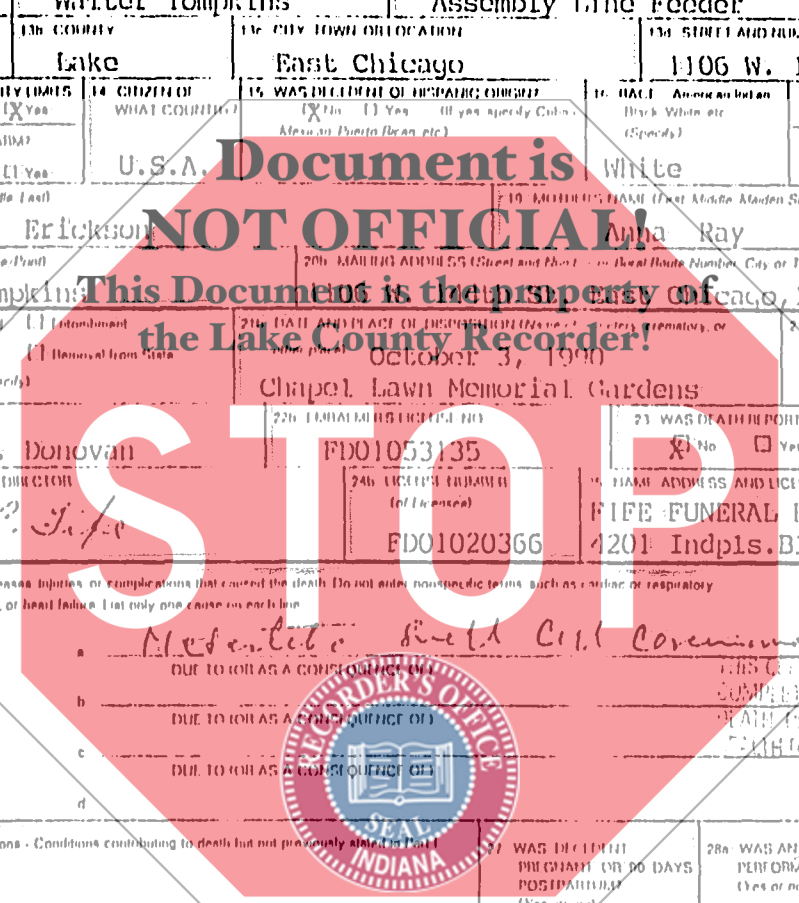
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



FILED

FEB 28 1992

David H. Antose
AUDITOR LAKE COUNTY

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