Shirley A. Comer
Subdiv NW S.29 T.37 R.9
Lot 31, Bl 13
Key# 30-6-32

92013691

Local No. 1986-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): MARGARET E. TOMPKINS
2. SEX: FEMALE
3a. TIME OF DEATH: 7:05 P.M.
3b. DATE OF DEATH: SEPTEMBER 29, 1990
4. SOCIAL SECURITY NUMBER: 398-07-7459
5a. AGE - Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): April 1, 1918
7. BIRTHPLACE (City and State or Foreign Country): Eleva, Wisconsin
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? -
9a. PLACE OF DEATH (Check only one): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] 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. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Assembly Line Feeder
12b. KIND OF BUSINESS/INDUSTRY: Pepsi-Cola Co.
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: East Chicago
13d. STREET AND NUMBER: 1106 W. 144th Street
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY: U.S.A.
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): 3; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Peter Erickson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Ray

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Walter Tompkins
20b. MAILING ADDRESS (Street and No. or Rural Route Number, City or Town, State, Zip Code): 1106 W. 144th Street East Chicago, IN 46312
20c. Relationship: Husband

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): October 3, 1990 Chapel Lawn Memorial Gardens
21c. LOCATION - City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Woodrow W. Donovan
22b. EMBALMER'S LICENSE NO.: FD01053135
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John R. Fife
24b. LICENSE NUMBER (of Licensee): FD01020366
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls. Blvd. East Chicago, IND

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. Metastatic Small Cell Carcinoma — Approximate Interval Between Onset and Death: 1 yr
DUE TO (OR AS A CONSEQUENCE OF):
b.
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
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): -

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]
29c. MEDICAL LICENSE NO.: 29782
29d. DATE SIGNED (Month, Day, Year): SEPTEMBER 30, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. MOHAMMAD Y. ALI M.D. 9116 COLUMBIA AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): October 1, 1990

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

SBH06-004 State Form 10110 (R2/3-89)

STATE OF INDIANA S.S. NO. 3 21 PM '92 ROBERT ... RECORDER FILED FOR RECORD

THIS CERTIFICATE ... COMPLETED ... FEB ... 1992

FILED
FEB 28 1992
Anna M. Antone
AUDITOR LAKE COUNTY

6.00

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