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INDIANA STATE BOARD OF HEALTH

Local No. 0751-92

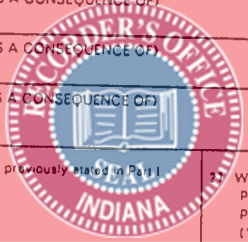
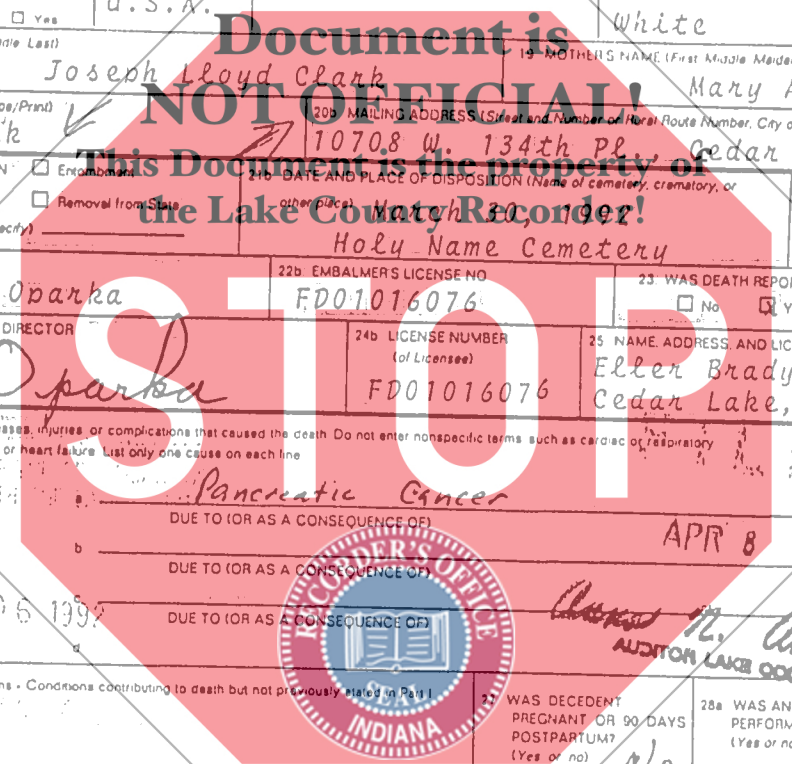
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Celestine Paul Clark		2 SEX Male	3a TIME OF DEATH 12:48 A.M.	3b DATE OF DEATH (Month Day Year) March 28, 1992	
4 SOCIAL SECURITY NUMBER 313-01-4484A	5a AGE—Last Birthday (Years) 81	5b HEIGHT—FEET INCHES 5 11	5c WEIGHT—POUNDS 170	6 DATE OF BIRTH (Month Day Year) June 21, 1910	
7 BIRTHPLACE (City and State or Foreign Country) Litchfield, Kentucky	8a WAS DECEDENT A US VETERAN? No				
8b YEAR LAST SERVED IN US ARMED FORCES?		9a PLACE OF DEATH (Specify only one type and structure) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Home <input type="checkbox"/>			
9b FACILITY NAME (If not institution give street and number) 10708 West 134th Place		9c CITY TOWN OR LOCATION OF DEATH Cedar Lake	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Freda Clark	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Stillman	12b KIND OF BUSINESS/INDUSTRY Oil refinery		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Cedar Lake	13d STREET AND NUMBER 10708 W. 134th Place		
13e ZIP CODE 46303	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) White	
17 DECEASED'S EDUCATION (Specify only highest grade completed) 12		17b College (1-4 or 5 +)			
18 FATHER'S NAME (First Middle Last) Joseph Lloyd Clark		19 MOTHER'S NAME (First Middle Maiden Surname) Mary Ange Cook			
20a INFORMANT'S NAME (Type/Print) Freda Clark		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 10708 W. 134th Pl., Cedar Lake, In. 46303		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 8, 1992 Holy Name Cemetery		21c LOCATION—City or Town State Cedar Lake, Indiana	
22a EMBALMER'S NAME Fred Oparka		22b EMBALMER'S LICENSE NO. FD01016076	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR Fred Oparka		24b LICENSE NUMBER (of License) FD01016076	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Ellen Brady FH83000825 Cedar Lake, Indiana 46303		
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. Pancreatic Cancer APR 06 1992					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Pancreatic Cancer b. APR 06 1992					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last APR 06 1992					
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)		
29a CERTIFIER (Check only one) <input 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 checked="" 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					
29b SIGNATURE AND TITLE OF CERTIFIER B.S. Drasga		29c MEDICAL LICENSE NO. 01031484	29d DATE SIGNED (Month Day Year) March 31, 92		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ray E Drasga, 8127 Merrillville Road, Suite 2, Merrillville, IN 46410					
31 HEALTH OFFICER'S SIGNATURE Alexander Williams MD				32 DATE FILED (Month Day Year) April 6, 1992	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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			

#24-1546
 CORONER ONLY
 HEALTH OFFICER
 CERTIFIER
 CAUSE OF DEATH
 DISPOSITION
 INFORMANT
 PARENTS
 DECEASED
 TYPE/PRINT IN PERMANENT BLACK INK



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