92022920

Local No. 0501-92

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

Scott Hoover
313 E. Commercial Ave
Lowell IN 46356

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Ronald F. Strickhorn
2. SEX: M
3a. TIME OF DEATH: 5:05 am
3b. DATE OF DEATH (Month, Day, Yr.): Feb 25, 1992
4. SOCIAL SECURITY NUMBER: 311-03-6634
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr.): May 17, 1911
7. BIRTHPLACE (City and State or Foreign Country): In
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Anthonys Med. 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): Barbara Clemens
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired Farmer
12b. KIND OF BUSINESS/INDUSTRY: Farm
13a. RESIDENCE—STATE: In
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Lowell
13d. STREET AND NUMBER: 4001 W. 221 Ave.
13e. ZIP CODE: 46356
13f. INSIDE CITY LIMITS: ☐ No ☐ Yes
13g. ON A FARM?: ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: Usa
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): W
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Strickhorn
19. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Allison

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Barbara Strickhorn
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4001 W. 221 Ave. Lowell, In
20c. Relationship: Spouse

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Feb 27 1992 Lowell Cemetery
21c. LOCATION—City or Town, State: Lowell, In
22a. EMBALMER'S NAME: Kenneth P. Sheets
22b. EMBALMER'S LICENSE NO.: FD08900045
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD0890045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home 604 E. Commercial Lowell In. FD8300427

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. Cerebral Hemorrhage — Approximate Interval Between Onset and Death: days
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Vascular Disease — years
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 resulting in the underlying cause given in Part I: [illegible]

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): no

MAR 19 1992

CERTIFIER

29a. CERTIFIER (Check only one)
☒ 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.: 02001002
29d. DATE SIGNED (Month, Day, Year): 2-28-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Richard Krejsa 2068 Lucus Parkway, Lowell, In. 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): March 3, 1992

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.

APR 17 1992

00868

[signature]
AUDITOR LAKE COUNTY

W1/2 W1/2 SE 8-32-8 40ac

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

UNIT KEY NUMBER	LEGAL DESCRIPTION
02-0300120006	W1/2. W1/2. SE. S.18 T.32 R.8 40AC.
02-0300130009	NE Corner of NW1/4 S.19 T.32 R.8 (180 FT. x 242 FT.) 1AC.
02-0301290007	Shelby L.7 BL.30