

Key# 36-203-7
Towles and Add
Alva L. 74 Alva B. 2
Local No. 36

INDIANA STATE BOARD OF HEALTH
FEB 6 1992
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jan 15 1992
Date Issued
Hammond Health Commissioner

92027164

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First Middle Last) James W. Jones		2. SEX Male		3a. TIME OF DEATH 8:06 p.m.		3b. DATE OF DEATH (Month Day Yr) January 13 1992	
4. SOCIAL SECURITY NUMBER 307-01-0655		5a. AGE—Last Birthday (Years) 93		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo Day Yr) April 21, 1898		7. BIRTHPLACE (City and State of Foreign Country) Lawrenceville, Illinois					
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 for instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DDA 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) St. Margaret Hospital				9c. CITY, TOWN OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife give maiden name) Lucille Ward		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Boilermaker		12b. KIND OF BUSINESS/INDUSTRY Construction	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Hammond		13d. STREET AND NUMBER 4437 Hohman Avenue	
13e. ZIP CODE 46327		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
13g. ON A FARM? <input type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) 8			
18. FATHER'S NAME (First Middle Last) Alfred Jones				19. MOTHER'S NAME (First Middle Maiden Surname) Sarah Goff			
20a. INFORMANT'S NAME (Type/Print) Mrs. Lucille Jones		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4437 Hohman Ave., Hammond, IN 46327				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) January 16, 1992 Calumet Park Cemetery				21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Charles D. Scheuer, Jr.		22b. EMBALMER'S LICENSE NO. 1006049		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer, Jr.</i>		24b. LICENSE NUMBER (of Licensee) 1006049		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME VIRGIL HUBER Funeral Home - 3002869 7051 Kennedy, Hammond, IN 46323			
26. PART I Enter the disease, 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. <i>S.P.O.S.I.S.</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Urinary Tract Infection</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Urinary Tract Infection</i> DUE TO (OR AS A CONSEQUENCE OF) d. <i>Urinary Tract Infection</i> DUE TO (OR AS A CONSEQUENCE OF)							
Approximate Interval Between Onset and Death <i>25 Days</i> <i>25 Days</i>							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>CONGESTIVE HEART FAILURE</i>							
27a. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		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>Charles E. Foreit, D.O.</i>					
28c. MEDICAL LICENSE NO. 209		28d. DATE SIGNED (Month, Day, Year) January 14, 1992					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) C. E. Foreit, D.O. 3831 Hohman Avenue, Hammond, Indiana 46327							
31. HEALTH OFFICER'S SIGNATURE <i>Granahm D. Pennell, M.D.</i>						32. DATE FILED (Month, Day, Year) January 15, 1992	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or No) FILED	
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) APR 19 1992		34e. DESCRIBE HOW INJURY OCCURRED					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) (If yes specify driver, passenger, and other persons involved) <i>600</i> AUDITOR LAKE COUNTY					

