

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Donald Shroy  
12441 - 119th St.  
Whiting, IN 46394

Local No. ....

92035011

State No. ....

TYPE/PRINT  
IN:  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) <b>ERCEL C. PETTY</b>		2 SEX <b>MALE</b>		3a TIME OF DEATH <b>2:32 A.M.</b>		3b DATE OF DEATH (Month Day, Yr) <b>APRIL 26, 1991</b>	
4 SOCIAL SECURITY NUMBER <b>404-16 0294</b>		5a AGE—Last Birthday (Years) <b>70</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day, Yr) <b>Sept. 27, 1920</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Fordsville, KY</b>					
8a WAS DECEDENT A US VETERAN? <b>Yes</b>		8b YEAR LAST SERVED IN US ARMED FORCES? <b>1946</b>		9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) <b>THE COMMUNITY HOSPITAL</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>MUNSTER</b>		9d COUNTY OF DEATH <b>LAKE</b>	
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Bernice Sapp</b>		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Supervisor</b>		12b KIND OF BUSINESS/INDUSTRY (Specify) <b>American, Maize</b>	
13a RESIDENCE—STATE <b>IN</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>Munster</b>		13d STREET AND NUMBER <b>8805 Jane Way #2</b>	
13e ZIP CODE <b>46321</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>White</b>		17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (13 or 14) <b>8</b>					
18 FATHER'S NAME (First, Middle Last) <b>Francis Marion Petty</b>				19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Lou Royal</b>			
20a INFORMANT'S NAME (Type/Print) <b>Bernice Petty</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8805 Jane Way #2 Munster, In 46321</b>		20c Relationship <b>Wife</b>	
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) <b>April 29, 1991 Fordsville Cemetery</b>		21c LOCATION—City or Town, State <b>Fordsville, KY</b>			
22a EMBALMER'S NAME <b>James Porras</b>		22b EMBALMER'S LICENSE NO. <b>1045964</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J Burns</i>		24b LICENSE NUMBER (of License) <b>1045184</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish Funeral Home #3004964 8415 Calumet Munster, IN 46321</b>			
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) <b>Respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Massive Cerebral Vascular Occlusion</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Myocardial Infarction</b>		APPROXIMATE Interval Between Onset and Death <b>12-24 hours</b>		THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. <b>APR 29 1991</b>			
PART II Other significant conditions - Conditions contributing to death but not proximately related thereto		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>	
29a 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.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Alexander Williams, MD</i>		29c MEDICAL LICENSE NO. <b>19183</b>		29d DATE SIGNED (Month, Day, Year) <b>APRIL 29 1991</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>RONALD FELDNER, M.D., 110 RIDGE ROAD, MUNSTER, INDIANA 46321</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>		32 DATE FILED (Month, Day, Year) <b>April 29, 1991</b>					
33 MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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. <b>01256/00</b>					

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

HEALTH OFFICER

CORONER USE ONLY

