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Tunedale Sub K.28 B1.15

Gary Guild Sub K.7 B1.3 + L.S B1.3

Key# 45-179-37

Key# 43-149-7; unit #25

INDIANA STATE BOARD OF HEALTH

Local No. 1148-92 92035316 CERTIFICATE OF DEATH State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Kermit Stovall		2 SEX Male	3a TIME OF DEATH 6:55 A.M.	3b DATE OF DEATH (Month, Day, Yr) May 19, 1992
4 SOCIAL SECURITY NUMBER 428-16-1528	5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo, Day, Yr) January 18, 1913
7 BIRTHPLACE (City and State or Foreign Country) Blue Springs, Mississippi	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

9a FACILITY NAME (If not institution, give street and number) Hobart Mercy Hospital	9b CITY, TOWN OR LOCATION OF DEATH Hobart	9c COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Lottie M. Leflore	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Laborer
12b KIND OF BUSINESS/INDUSTRY USX Steel Corp.	13a RESIDENCE—STATE Indiana	

PARENTS

13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 1102 Hovey Street
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input 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) Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12th	18 FATHER'S NAME (First, Middle, Last) Marshall Stovall	

INFORMANT
tax
mailing
address

19 MOTHER'S NAME (First, Middle, Maiden Surname) Unknown	20a INFORMANT'S NAME (Type/Print) Lottie M. Stovall	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Hovey Street, Gary, Indiana 46404	20c Relationship Wife
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DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) May 23, 1992 Evergreen Cemetery	21c LOCATION—City or Town, State Hobart, Indiana
22a EMBALMER'S NAME Roosevelt Allen Sr.	22b EMBALMER'S LICENSE NO. #01051696	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes

THIS IS THE COMPLETE DEATH HEALTH

24 SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b LICENSE NUMBER (of Licensee) 08700298	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404 85007704
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CAUSE OF DEATH

28 PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. MAY 28 1992 Coronary Heart Failure Cardiomyopathy	Approximate Interval Between Onset and Death JUN 3 9 20
IMMEDIATE CAUSE (Final disease or condition resulting in death) Coronary Heart Failure	STATE OF INDIANA FILED FOR RECORDING
28a. DUE TO (OR AS A CONSEQUENCE OF) IMMEDIATE CAUSE	
28b. DUE TO (OR AS A CONSEQUENCE OF) IMMEDIATE CAUSE	
28c. DUE TO (OR AS A CONSEQUENCE OF) IMMEDIATE CAUSE	

LAKE

28 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I. Renal failure	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
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CERTIFIER

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>[Signature]</i> Dr. Billena	29c. MEDICAL LICENSE NO. 1026069	29d. DATE SIGNED (Month, Day, Year) 5-22-92
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HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) 5490 Broadway Plaza - Merrillville, In. 46410	31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> Alexander S. Billena, M.D.	32. DATE FILED (Month, Day, Year) May 28, 1992
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CORONER USE ONLY

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. WHERE AND 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) JUN 3 1992 <i>[Signature]</i> CLARENCE COUNTY	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver's license number, department, etc.			