92039578

Local No. 387

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

May 1, 1992 — Date Issued — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Lucille H. King
2. SEX: Female
3a. TIME OF DEATH: 2:58 a.m.
3b. DATE OF DEATH (Month Day Yr): April 29, 1992
4. SOCIAL SECURITY NUMBER: 307-22-1063
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr): October 12, 1923
7. BIRTHPLACE (City and State or Foreign Country): Bryson, North Carolina
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 ☐ Other (Specify) ☐ 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): Arvelee King
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: at home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 409 Vine Street
13e. ZIP CODE: 46324
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): white
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Luther Anthony
19. MOTHER'S NAME (First Middle Maiden Surname): Victoria Sizemore

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Arvelee King
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 409 Vine Street, Hammond, Indiana 46324
Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Concordia Cemetery, May 2, 1992
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Rod A. Ivy
22b. EMBALMER'S LICENSE NO.: FDO1018769
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Rod A. Ivy
24b. LICENSE NUMBER (of Licensee): FDO1018769
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: C.J. Huber Funeral Home FDH3002851, 722 165th Street Hammond, Indiana 46324

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Multiple organ Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Bowel [illegible]
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II: Other significant conditions: Conditions contributing to death but not previously stated in Part I: Thrombocytopenia

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): N/A

FILED JUN 19 1992 — Auditor Lake County

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: H. Alan Jones, D.O.
29c. MEDICAL LICENSE NO.: 640
29d. DATE SIGNED (Month, Day, Year): April 29, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): H. A. Jones, D.O. 9128 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32. DATE FILED (Month, Day, Year): May 1, 1992

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

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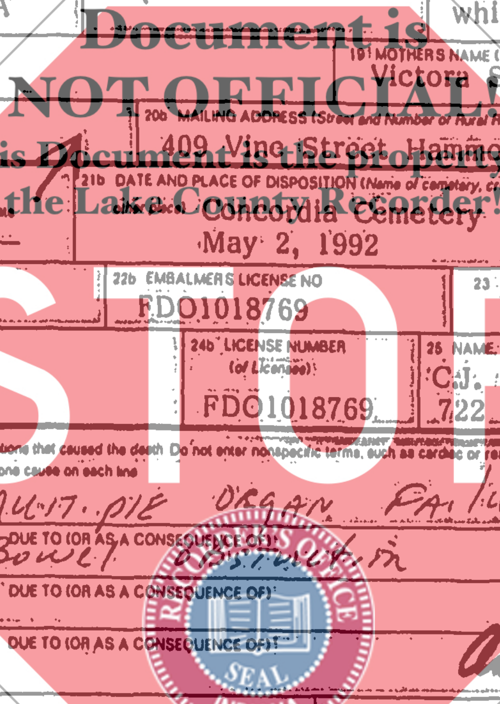
Key# 34-3-45 (47) F.B. Halls Sub. L 42 To 45 Bl 3

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



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