

92071037

INDIANA STATE BOARD OF HEALTH

Writting In 46394

Local No. 2109-91

CERTIFICATE OF DEATH

State No. ParkView Add h-1 B1.10 Key # 35 229-1 unit # 26

TYPE/PRINT IN PERMANENT BLACK INK
DECEASED
Forsyth Water Condens W part of E 33ft of lot 11, B13
PARENTS
Forsyth's Sheffield Sub S.40ft lot B16
CAUSE OF DEATH
Harvey's Subdy W 1/2 l. 28 + call h. 29 Key # 29-52-27 unit # 28
CERTIFIER
HEALTH OFFICER
CORONER USE ONLY
Pt SE NE S. 7 T. 37 R. 9 .07A Key # 29-3-12 unit # 28

1 DECEASED—NAME (First Middle Last) LAWRENCE G. WILLIAMS		2 SEX MALE	3a TIME OF DEATH 7:00 A.M.	3b DATE OF DEATH (Month Day, Yr) OCTOBER 13, 1991
4 SOCIAL SECURITY NUMBER 306-10-2664	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) JULY 12, 1918
7 BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA	8a WAS DECEDENT A US VETERAN? NO	8b YEAR LAST SERVED IN US ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA <input checked="" type="checkbox"/> Residence OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)	
9b FACILITY NAME (If not institution give street and number) 1649 SHERIDAN AVENUE		9c CITY TOWN OR LOCATION OF DEATH WHITING	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife give maiden name) BERNICE ALLEN	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) CARPENTER		12b KIND OF BUSINESS/INDUSTRY AMERICAN OIL CO.
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION WHITING	13d STREET AND NUMBER 1649 SHERIDAN AVENUE	
13e ZIP CODE 46394	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5 +)		18 FATHER'S NAME (First Middle Last) FRTTELL WILLIAMS		
19 MOTHER'S NAME (First Middle Maiden Surname) MARY FISCHER		20a INFORMANT'S NAME (Type/Print) BERNICE WILLIAMS		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State, Zip Code) 1649 SHERIDAN AVE WHITING, IN 46394		20c Relationship WIFE		
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) OCTOBER 15, 1991 OAKLAND MEMORY LANES		21c LOCATION—City or Town State DOLTON, ILLINOIS
22a EMBALMERS NAME THOS. OWENS		22b EMBALMERS LICENSE NO FDE1001049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thos Owens</i>		24b LICENSE NUMBER (of Licensee) FDE1001049		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME OWENS FUNERAL HOME FDH3007291 816-119th St., Whiting, IN 46394
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) <i>Cardiomyopathy of the lung</i> Conditions, if any, which gave rise to the immediate cause stating the underlying cause last NOV 09 1992				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Alzheimer's Disease</i>				
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)
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>Donald H. Rutser M.D.</i>		
29c MEDICAL LICENSE NO 01012942		29d DATE SIGNED (Month Day Year) 14 Oct 91		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) DONALD H. RUTSER, 1931 LAKE AVE. WHITING IN 46394				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>		32. DATE FILED (Month, Day, Year) Oct. 15, 1991		
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)
34d PLACE OF INJURY—At home farm street factory, office building, etc (Specify)		34e 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)		

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NOV 8 1992

James R. Rutser
AUDITOR LAKE COUNTY

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