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INDIANA STATE BOARD OF HEALTH

Local No. 1010-92 93002140 CERTIFICATE OF DEATH State No. 92-1494

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Albert G. Stoner
2 SEX: Male
3a TIME OF DEATH: 1:00 pm
3b DATE OF DEATH (Month Day Yr): May 3, 1992
4 SOCIAL SECURITY NUMBER: 349-01-2842A
5a AGE—Last Birthday (Years): 71
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): March May 21, 1921
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN? YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES? Aug. 31, 1945
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): 4806 White Oak Terrace
9c CITY, TOWN, OR LOCATION OF DEATH: Lowell
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Teresa Michiels
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: Construction
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Lowell
13d STREET AND NUMBER: 4806 White Oak Terrace
13e ZIP CODE: 46356
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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Harry Stoner
19 MOTHER'S NAME (First Middle Maiden Surname): Ruth Ottostein

INFORMANT

20a INFORMANT'S NAME (Type/Print): Teresa Stoner
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4806 White Oak Terrace Lowell, In 46356
20c Relationship: Spouse

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): May 6, 1992 Lowell Memorial Park Cemetery
21c LOCATION—City or Town, State: Lowell, Indiana
22a EMBALMER'S NAME: Kenneth P. Sheets
22b EMBALMER'S LICENSE NO: FD08900045
23 WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Kenneth P. Sheets
24b LICENSE NUMBER (of Licensee): FD08900045
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home 3004277 604 E. Commercial Ave. Lowell, In

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. Cancer — Metastatic
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
MAY 07 1992

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

27. WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or no)
28a WAS AN AUTOPSY PERFORMED? (Yes or no)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED JAN 06 1993 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:
29c MEDICAL LICENSE NO: 5000-2521
29d DATE SIGNED (Month, Day, Year): 5-6-92

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Randall Hile Md 1020 E. Commercial Ave. Lowell, IN 46356
31. HEALTH OFFICER'S SIGNATURE: Alexander S. Hilkevitch, M.D.
32. DATE FILED (Month, Day, Year): May 7, 1992

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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 Ooccurred
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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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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