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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 140-91 State No. ....

93017323

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	WILLIAM J. Mc MILLEN
2. Sex	MALE
3a. Time of Death	4:25P.M.
3b. Date of Death (Month Day Yr)	JANUARY 20, 1991
4. Social Security Number	309-42-5658
5a. Age—Last Birthday (Years)	53
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo. Day, Yr)	DEC. 3, 1937
7. Birthplace (City and State or Foreign Country)	VINCENNES, INDIANA
8a. Was Decedent a U.S. Veteran?	YES
8b. Year Last Served in U.S. Armed Forces?	U.S. ARMY
9a. Place of Death (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. Facility Name (If not institution, give street and number)	METHODIST HOSPITAL SOUTHLAKE CAMPUS
9c. City, Town or Location of Death	MERRILLVILLE
9d. County of Death	LAKE
10. Marital Status (Specify)	MARRIED
11. Surviving Spouse (If wife, give maiden name)	RUTH E. FIRME
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	UTILITY OPERATOR
12b. Kind of Business/Industry	SCOT LAD FOODS
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town or Location	MERRILLVILLE
13d. Street and Number	926 W. 72ND PLACE
13e. Zip Code	46410
13f. Inside City Limits	[ ] No [X] Yes
13g. On a Farm?	[X] No [ ] Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
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

Field	Entry
18. Father's Name (First, Middle, Last)	CHARLES HENRY McMILLEN
19. Mother's Name (First, Middle, Maiden Surname)	AMELIA VIRGINIA MANNING

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	RUTH E. McMILLEN
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	926 W. 72ND PL. MERRILLVILLE, IN 46410
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. Method of Disposition	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	JANUARY 23, 1991 CALUMET PARK CEMETERY
21c. Location—City or Town, State	MERRILLVILLE, IN
22a. Embalmer's Name	GORDON L. JONES
22b. Embalmer's License No.	1001071
23. Was Death Reported to Coroner?	[X] No [ ] Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	1009461
25. Name, Address, and License Number of Funeral Home	BURNS FUNERAL HOME FDH: 8600018 10101 BROADWAY CROWN POINT, IN 46307

THIS CERTIFIES THE ABOVE IS A TRUE ... COMPLETE ... DEATH ON FILE WITH ... HEALTH DEPT ...

DEC 11 1991

LAKE COUNTY HEALTH COMMISSIONER

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.	Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF): b.	[illegible handwriting] heart disease	
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II. Other significant conditions—Conditions contributing to death but not resulting in the underlying cause given 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)
NO	NO	

CERTIFIER

29a. Certifier (Check only one)
- [X] 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.	29d. Date Signed (Month, Day, Year)
[signature]	01026057	1-22-91

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): DR. ARUN K. GOEL 209 EAST 86 COURT MERRILLVILLE, IN 46410

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month, Day, Year)
Robert Guthrie, DO	January 22, 1991

CORONER USE ONLY

Field	Entry
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 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.	

MAR 3 1993

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Auditor Lake County

SAM ... RECORDER ... MAR 18 2 10 PM '93 ... FILED FOR RECORD ... LAKE COUNTY ... STATE OF INDIANA S.S. NO.

4640 926 W. 72nd Pl. Merr. TXS 4l. 2 67 ... Turkey Creek Sub. Unit 2

15-463-18

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SBH06-004 State Form 10110 (R2/3-89)