# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

Local No. 254-90 93018840

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First, Middle, Last) | | | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|---|---|
| HARRY | E. | DICKSON SR | Male | 2:55P M. | December 13, 1990 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR: Months / Days | 5c. UNDER 1 DAY: Hours / Minutes | 6. DATE OF BIRTH (Mo. Day, Yr.) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 317-09-9055 | 73 | | | FEB 1, 1917 | GALLATIN, TENNESSEE |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions) |
|---|---|---|
| No | N/A | HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| ST. MARY MEDICAL CENTER | HOBART | LAKE |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | EVELYN M. RITTER | OPERATOR/DRIVER | GARY RAILWAYS |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | LAKE | HOBART | 409 ARTHUR STREET |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| 46342 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | ☒ No ☐ Yes | WHITE | Elementary/Secondary (0-12) 12 | College (1-4 or 5+) |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| FRANCIS OMAR DICKSON | ORA FUSSELL |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| EVELYN DICKSON | 409 ARTHUR STREET, HOBART, IN 46342 | WIFE |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Other (Specify) ☐ Removal from State | DEC 17 1990 CALUMET PARK CEMETERY | MERRILLVILLE, INDIANA |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| JAMES W. GHOLSTON | FD01004194 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| James W. Kraus | FD01006463 | FH83003069 REES FUNERAL HOME 600 W. OLD RIDGE RD. HOBART, IN 46342 |

**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 arrhythmia | Minutes |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | b. DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease | Years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions. Conditions contributing to death but not resulting in Part I: C.O.P.D.

| 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 | N/A |

**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. | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| David L. Koenig M.D. | 010174521 | 12/17/90 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ROBERT L. KOENIG MD, 1101 EAST GLENDALE BLVD, VALPARAISO, IN 46383

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month, Day, Year) |
|---|---|
| Robert Guthrie MD | DEC. 18, 1990 |

**CORONER USE ONLY**

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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: