93019341

Local No. 25 41-90

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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?	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)	
	13g ON A FARM?				Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	☐ No ☒ Yes / ☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	11	

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 ☐ Removal from State ☐ Donation ☐ Other (Specify)	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 J. Krauss	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 Arrest	Minutes
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction	Minutes
	c. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease	Years
	d. DUE TO (OR AS A CONSEQUENCE OF):	

THIS CERTIFICATE IS AN EXACT COPY OF THE ORIGINAL DEATH CERTIFICATE ON FILE IN THE LAKE COUNTY HEALTH DEPARTMENT

MAR 12 1993

PART II. Other significant conditions - Conditions contributing to death but not previously listed 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)
C.O.P.D.	N/A	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.	01017451	12/17/90

HEALTH OFFICER

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

31. HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Robert Guthrie M.D.	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