Key# 15-577-3
Innsbrook Unit 2
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OFFICIAL COPY
MARION COUNTY HEALTH DEPARTMENT
222 E. OHIO ST. INDIANAPOLIS, IND.
CERTIFICATE OF DEATH

Local No. 93025696

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (First Middle Last): Joseph George Richardson, Jr.
2. SEX: Male
3a. TIME OF DEATH: 0246
3b. DATE OF DEATH (Month Day Yr): December 26, 1990
4. SOCIAL SECURITY NUMBER: 199-10-4407
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY
6. DATE OF BIRTH: August 3, 1920
7. BIRTHPLACE (City and State or Foreign Country): Pittsburgh, Pa.
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
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): St. Vincent Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Indianapolis
9d. COUNTY OF DEATH: Marion
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mary Lisak
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Engineer
12b. KIND OF BUSINESS/INDUSTRY: Koppers Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Merrillville
13d. STREET AND NUMBER: 2498 West 64th Avenue
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS? [X] No [ ] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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+): 2

PARENTS

18. FATHER'S NAME (First Middle Last): Joseph George Richardson, Sr.
19. MOTHER'S NAME (First Middle Maiden Surname): Harriet Reges

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary Jean Richardson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2498 W. 64th. Ave., Merrillville, In. 46410
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 31, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: David R. Gerber
22b. EMBALMER'S LICENSE NO.: 1043263
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: David R. Gerber
24b. LICENSE NUMBER (of Licensee): 1043263
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. 8900762 7905 Broadway, Merrillville, In. 46410

FILED APR 23 1993

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	8 HRS
DUE TO (OR AS A CONSEQUENCE OF) b.	Ischemic Heart Disease	YRS
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

Sequentially list conditions, if any, leading to the immediate cause. Enter the underlying cause last.

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Left Ventricular Dysfunction, Mitral Regurgitation, Chronic Obstructive Lung Disease, Hypertension

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)

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: Edward B. Fitzgerald MD
29c. MEDICAL LICENSE NO.: 22163
29d. DATE SIGNED (Month, Day, Year): 12-26-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Edward B. Fitzgerald, MD, 8402 Harcourt Rd., Indianapolis, In 46260

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): DEC 31 1990

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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.

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

NOT VALID UNLESS MACHINE NUMBERED AND SIGNED WITH MULTICOLOR RIBBON