93028415

NEWTON COUNTY BOARD OF HEALTH

Judy Alliss 1040 Jennings Pl 77 Cu Pt 46307

Local No. C-56-010-90

# CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): Marie Alliss
2. SEX: Female
3a. TIME OF DEATH: 7:55 A.M.
3b. DATE OF DEATH (Month, Day, Yr.): July 19, 1990
4. SOCIAL SECURITY NUMBER: 307-20-2971
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): July 31, 1912
7. BIRTHPLACE (City and State or Foreign Country): Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
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): Sumava Rd. & 41 North Bound Lane
9c. CITY, TOWN, OR LOCATION OF DEATH: Sumava
9d. COUNTY OF DEATH: Newton
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Frank Alliss
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Custodian
12b. KIND OF BUSINESS/INDUSTRY: School System
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Schneider
13d. STREET AND NUMBER: 9603 W. 236th Box 152
13e. ZIP CODE: 46376
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): Whtie
17. DECEDENT'S EDUCATION (Specify only highest grade completed): # Elementary/Secondary (0-12): / College (1-4 or 5+):

**PARENTS:**

18. FATHER'S NAME (First, Middle, Last): Charlie Gerz
19. MOTHER'S NAME (First, Middle, Maiden Surname): Alma Ohlenkamp

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Frank Alliss
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9603 W. 236th Box 152 Schneider, IN 46376
20c. Relationship: Spouse

tax mailing address

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): July 20, 1990 West Creek Cemetery
21c. LOCATION—City or Town, State: Lowell, IN
22a. EMBALMER'S NAME: William A. Sheets
22b. EMBALMER'S LICENSE NO.: FD1053460
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William A. Sheets
24b. LICENSE NUMBER (of Licensee): FD1053460
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home 604 Commercial Lowell, IN FD83004277

**CAUSE OF DEATH**

26. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter conspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Due to Multiple Injuries to head and neck
DUE TO (OR AS A CONSEQUENCE OF): b.
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

Approximate Interval Between Onset and Death: Immediate

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): no
28. AUTOPSY PERFORMED? (Yes or no): no
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): n/a

FILED MAY 4 1993

**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: Gerald A. Burman Coroner
29c. MEDICAL LICENSE NO.:
29d. DATE SIGNED (Month, Day, Year): July 29, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): GERALD A. BURMAN, 105 W. Iroquois Dr., Kentland, IN. 47951

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: John C. Parker, M.D.
32. DATE FILED (Month, Day, Year): Aug. 3, 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): July 19, 1990
34b. TIME OF INJURY: 7:55a.m.
34c. INJURY AT WORK? (Yes or no): no
34d. DESCRIBE HOW INJURY OCCURRED: Motor Vehicle accident
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): U.S. Highway
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): U.S.41 / Sumava entrance
34g. DATE PRONOUNCED DEAD (Month, Day, Year): July 19, 1990
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: Yes, Driver

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD I

Pt. NE NE 112.96X75.02X114.73X75ft Tract 3 S.33 T.32 R.9 0.198AC
Key #2-4-10 ; Unit #21

NEWTON COUNTY HEALTH DEPARTMENT
MOROCCO, INDIANA 47963
THIS IS A TRUE COPY OF THE ORIGINAL RECORD
John C. Parker, M.D.
HEALTH OFFICER

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Pt. NE NE 75X114.77X75.02X116.49ft Tract 4
S 33 T.32 R.9 0.198AC Key #2-4-11
Unit #21

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