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3351 Jasper St
Hobart In 46342
Joann Howell

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 312 93040118

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): Gerald L. Howell
- 2. SEX: Male
- 3a. TIME OF DEATH: 7:30 P.M.
- 3b. DATE OF DEATH (Month, Day, Yr): November 3, 1991
- 4. SOCIAL SECURITY NUMBER: 403-46-8012
- 5a. AGE—Last Birthday (Years): 54
- 5b. UNDER 1 YEAR: Months / Days
- 5c. UNDER 1 DAY: Hours / Minutes
- 6. DATE OF BIRTH (Mo, Day, Yr): April 17, 1937
- 7. BIRTHPLACE (City and State or Foreign Country): Kentucky
- 8a. WAS DECEDENT A U.S. VETERAN?: Yes
- 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 ☐ Residence ☐ Other (Specify)
- 9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
- 9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Married
- 11. SURVIVING SPOUSE (If wife, give maiden name): JoAnn Winstead
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver
- 12b. KIND OF BUSINESS/INDUSTRY: Inland Steel
- 13a. RESIDENCE—STATE: Indiana
- 13b. COUNTY: Lake
- 13c. CITY, TOWN, OR LOCATION: Hobart
- 13d. STREET AND NUMBER: 3351 Jasper Street
- 13e. ZIP CODE: 46342
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Howard Howell
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Maudlene LaRue

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): JoAnn Howell
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3351 Jasper St., Hobart, Indiana 46342
- 20c. Relationship: Wife

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 6, 1991 Calumet Park Cemetery
- 21c. LOCATION—City or Town, State: Merrillville, Indiana
- 22a. EMBALMER'S NAME: Alexis Thanos
- 22b. EMBALMER'S LICENSE NO.: FD08600505
- 23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Mabel J. Geisen (signature)
- 24b. LICENSE NUMBER (of Licensee): FD01041740
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762, 7905 Broadway, Merrillville, In. 4641[illegible]

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Rupture of saccular atherosclerotic aneurysm of left vertebral artery — Approximate Interval Between Onset and Death: Unknown

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

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 previously stated in Part I

- 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
- 28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
- 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

FILED JUN 22 1993

Anne M. Anton (signature) RECORDER LAKE COUNTY

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: Daniel D. Thomas (signature)
- 29c. MEDICAL LICENSE NO.: 16120
- 29d. DATE SIGNED (Month, Day, Year): November 6, 1991
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Dr. Jonathan Rankovich (signature)
- 32. DATE FILED (Month, Day, Year): 11-6-91

CORONER USE ONLY

- 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): November 3, 1991
- 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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Viking Will Rt 38 #16- 274-38

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

6.00