1 93041969

Ida Hughes

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 1795-91 State No. 71

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): THERMAN R. HUGHES
2. SEX: Male
3a. TIME OF DEATH: 12:10 pm
3b. DATE OF DEATH (Month Day Yr): September 2, 1991
4. SOCIAL SECURITY NUMBER: 314-09-6287
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): June 16, 1918
7. BIRTHPLACE (City and State or Foreign Country): Hurricane, West Virginia
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: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Anthony Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Ida Wilson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance Man
12b. KIND OF BUSINESS/INDUSTRY: Graver Tank Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 12027 Cline Ave.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: XX No ☐ Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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) / College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First Middle Last): Charles Edgar Hughes
19. MOTHER'S NAME (First Middle Maiden Surname): Daisy Bell Romine

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ida Hughes
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12027 Cline Ave., Crown Pt., IN 46307
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): September 4, 1991 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Dean G. Wagner
22b. EMBALMER'S LICENSE NO.: 08800057
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN & LITTLE FUNERAL SERVICE #83001261 811 E. Franciscan Dr., Crown Point, IN 46307

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.	Congestive Heart failure	3 days
DUE TO (OR AS A CONSEQUENCE OF): b.	Acute myocardial infarction	3 days
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

PART II. Other significant conditions - Conditions contributing to death but not causally related in Part I: Cerebrovascular Accident

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

CERTIFIER

29a. CERTIFIER (Check only one): XX 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: [signature]
29c. MEDICAL LICENSE NO.: 27841
29d. DATE SIGNED (Month, Day, Year): 9/3/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Trent Orfanos M.D., 297 Franciscan Drive, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D. COUNTY HEALTH COMMISSIONER
32. DATE FILED (Month, Day, Year): Sept. 3, 1991

FILED

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.

JUN 29 1993

Anna N. Antonas AUDITOR LAKE COUNTY

92014

THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY

SEP 03 1991

7-170-21, 23, 26 & 27, Porter Co's Woodland Est Lots 43, 45, 47 & 49

6/29/93 Ly

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

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