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INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 2012-92   93046396   State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Lawrence C. Kelley
2 SEX: Male
3a TIME OF DEATH: 6:25A. M
3b DATE OF DEATH (Month Day Yr): September 21,1992
4 SOCIAL SECURITY NUMBER: 307-01-5029
5a AGE—Last Birthday (Years): 79
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day, Yr): June 11,1913
7 BIRTHPLACE (City and State or Foreign Country): Delphi,Indiana
8a WAS DECEDENT A US VETERAN?: Yes
8b YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): Southlake Care Nursing Home
9c CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Enid E. Humphrey
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Owner & Operator
12b KIND OF BUSINESS/INDUSTRY: Larry Kelley Sign,Inc.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Crown Point
13d STREET AND NUMBER: 805 Kenmare Parkway
13e ZIP CODE: 46307
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): Alvin A. Kelley
19 MOTHER'S NAME (First Middle Maiden Surname): Burnetta E. Dyke

INFORMANT

20a INFORMANT'S NAME (Type/Print): Enid Kelley
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 805 Kenmare Parkway Crown point, In. 46307
20c Relationship: Wife

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): September 23,1992 Calumet Park Cemetery
21c LOCATION—City or Town State: Merrillville,INdiana
22a EMBALMER'S NAME: Alexis Thanos
22b EMBALMER'S LICENSE NO: FDO 8600505
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: William C. Geisen
24b LICENSE NUMBER (of Licensee): FDO 1003203
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home,Inc. FH 83007762 7905 Broadway Merrillville,in. 46410

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. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF): b. Dehydration
DUE TO (OR AS A CONSEQUENCE OF): c. Congestive heart failure
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 previously stated in Part I: Parkinson's disease

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

FILED JUL 19 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: [signature]
29c MEDICAL LICENSE No: 0103...
29d DATE SIGNED (Month, Day, Year): 9/22/92

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Surendra Shah 2520 Fairview Ave Lake Station,Indiana

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
32 DATE FILED (Month, Day, Year): September 23,1992

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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Wallford Lt 6-1 Phase 1 #9-43-11

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