

34-191-34  
Local No. 2377-91

93050798

FA-9421  
INDIANA STATE BOARD OF HEALTH  
CERTIFICATE OF DEATH

Return to:  
First American Title Insurance Company  
5 State National Bank Building  
Crown Point, IN 46307

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) <b>NORVIEL G. RAMSEY</b>		2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>5:50 PM</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>NOVEMBER 21, 1991</b>
4. SOCIAL SECURITY NUMBER <b>307-01-1619</b>	5a. AGE—Last Birthday (Years) <b>73</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Nov. 30, 1917</b>
7. BIRTH-PLACE (City and State or Foreign Country) <b>St. Francisville, IL</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>no</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>none</b>		9. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>OUR LADY OF MERCY</b>		9c. CITY, TOWN OR LOCATION OF DEATH <b>DYER</b>	9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Ruth A. Ackman</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). <b>Pumper-Operator</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Lever Bro. Co.</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Hammond</b>	13d. STREET AND NUMBER <b>7109 Harrison Avenue</b>	
13e. ZIP CODE <b>46324</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) <b>Clyde Ramsey</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Gher</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Mrs. Ruth A. Ramsey</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7109 Harrison Avenue Hammond, IN 46324</b>	20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>November 25, 1991 Chapel Lawn Memorial Gardens</b>		21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>
22a. EMBALMER'S NAME <b>David McCoy</b>		22b. EMBALMER'S LICENSE NO. <b>FDO8700581</b>	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of License) <b>FDO1013507</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Bocken Funeral Home, Inc. FH8300280 7042 Kennedy Avenue Hammond, IN 46324</b>	
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, check, or heart failure. List only one cause on each line. <b>Coronary artery atherosclerosis</b>				
27. PART II. Enter the diseases, injuries, or complications that contributed to death but not previously stated in Part I. <b>Anterior wall MI</b>				
28. NAME OF CAUSE OF DEATH <b>Coronary artery atherosclerosis</b>				
29. DATE OF DEATH <b>NOVEMBER 21, 1991</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>S. JOSIAH CHAN, D.O., 911 FRAN LYN PARKWAY MUNSTER, INDIANA 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>				32. DATE FILED (Month, Day, Year) <b>November 22, 1991</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) <b>JUL 30 1993</b>	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED <b>600 ft</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) <b>Yes</b> <b>Alexander S. Williams, MD</b> <b>AUDITOR LAKE COUNTY</b>		

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TE OF INDIANA S.S. NO. LAKE COUNTY  
4 10 38 AM '93

Unit # 26  
Key # 34-191-34  
Resub Pt Jackson Terr. All of lots 50 & 51 Bl. 6