Local No. 820-90 93053317

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Albert F. Arnold, Sr.	Male	10:35A.	April 9, 1990

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
322-20-9669	65yrs.			Dec. 26, 1924	Danville, Illinois

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes		HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Mary Medical Center	Hobart	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Paula Goodlink	Welder	Industrial Construc

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hobart	1620 E. 33rd Place

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	Unavailable

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas Arnold	Amy Thompson

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Paula Arnold	1620 E. 33rd Place, Hobart, IN 46342	Wife

21a METHOD OF DISPOSITION	21b PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	April 13, 1990 - Calvary Cemetery	Portage, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Roger A. Young	FDO 860 1323	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Roger A. Young	FDO 8601323	Young Funeral Home-FH83001643 1307 Central Ave., Lake Station, I

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. myocardial infarction	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF) Coronary	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

FILED AUG 16 1993 AUDITOR LAKE COUNTY

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)	28a WAS AN AUTOPSY PERFORMED?	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Died during Cardiac Catheterization	NO	NO	NA

29a CERTIFIER (Check only one) ☐ CERTIFYING PHYSICIAN ☐ HEALTH OFFICER ☐ CORONER

To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

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.

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[illegible] M.D.	22236	April 12, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

AUG 16 1993 [illegible]

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) April 12, 1990

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

LAKE COUNTY HEALTH COMMISSIONER

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.

SBH08-004 State Form 10110 (R2/3-89) DEA CERT/PD 1