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Local No. 229

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First Middle Last)	William H. Royal
2. SEX	Male
3a. TIME OF DEATH	9:06 P.M.
3b. DATE OF DEATH (Month Day Yr)	August 21, 1993
4. SOCIAL SECURITY NUMBER	234-18-3401
5a. AGE—Last Birthday (Years)	85
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day. Yr)	March 3, 1908
7. BIRTHPLACE (City and State or Foreign Country)	Parkersburg, W. Virginia
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN US ARMED FORCES?	----
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)	4040 Carey Street
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)	Frances Barnett
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Crane Operator (Retired)
12b. KIND OF BUSINESS/INDUSTRY	LTV Steel
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	East Chicago
13d. STREET AND NUMBER	4040 Carey Street
13e. ZIP CODE	46312
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	8th Grade
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	William Royal
19. MOTHER'S NAME (First Middle Maiden Surname)	Hattie Royal

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Frances C. Royal
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4040 Carey St. East Chicago, Indiana
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	August 25, 1993 Oak Hill Cemetery
21c. LOCATION—City or Town, State	Griffith, Indiana
22a. EMBALMER'S NAME	Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.	FD08600238
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee)	FD08600238
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Hinton-Williams Funeral Home FH830015 4859 Alexander Ave. East Chicago, In.

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. Carcinoma of prostate c metastases

DUE TO (OR AS A CONSEQUENCE OF):

b.

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 previously ... : Coronary artery disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): no

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	John C. Mason MD
29c. MEDICAL LICENSE NO.	01017753 IN
29d. DATE SIGNED (Month Day Year)	8-23-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	John C. Mason, M.D. 7905 Calumet Ave. Munster, IN. 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] MD.
32. DATE FILED (Month Day Year)	8-24-93

Field	Entry
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) Specify driver, passenger, pedestrian, etc.	

FILED

AUG 27 1993

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[signature]

AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

AUG 27 2 13 PM '93

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