94029628

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 4761-89

Deer Creek Acres Lot 2 Key # 10-53-2 Unit # 11

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2. SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
WILBUR H. UNDERWOOD	MALE	7:30P M	NOVEMBER 26, 1989

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)
307-01-5986	78			NOV. 19, 1911	WILDERS, INDIANA

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)
NO	N/A	HOSPITAL XX 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. ANTHONY MEDICAL CENTER	CROWN POINT	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	SYLVIA A. STANGEBYE	CARPENTER	MID-AMERICA HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	10807 GRAND BOULEVARD

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 +)
46307	XX No ☐ Yes	XX No ☐ Yes	USA	XX No ☐ Yes	WHITE	8	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
NORMAN UNDERWOOD	CAROLINE PFEIL

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
SYLVIA A. UNDERWOOD	10807 GRAND BOULEVARD, CROWN POINT, IN 46307	SPOUSE

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	NOVEMBER 29, 1989 DEER CREEK CEMETERY	CROWN POINT, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FD01004194	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Gerald Rees	FD01041083	REES FUNERAL HOME, INC. FDH3003069 600 W. RIDGE RD, HOBART, IN 46342

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

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)
NO	NO	N/A

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Milton S. Gasparis,	01037515	05 DEC 01 89

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
MILT GASPARIS, MD; P.O. BOX 457, DEMOTTE, IN 46310

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Gerald Johnson	DEC 8, 89

CORONER USE ONLY

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 ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	APR 19 1994

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	Anna M. Antosz AUDITOR LAKE COUNTY

FILED

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

2116?