6 plus vets 8 [illegible]

Broadway Home Acres
N½ L 2 ex. S 100 ft + ex N 100 ft of
W 65 ft + ex N 105 ft of E 71.4 ft

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 93-0427

State No.

Key #41-174-41 unit #25

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): RAYMOND CHESTER FULTON
2. SEX: MALE
3a. TIME OF DEATH: 12:59 A.M.
3b. DATE OF DEATH (Month Day Yr): JUNE 3, 1993
4. SOCIAL SECURITY NUMBER: 314-20-3784
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): FEBRUARY 8, 1925
7. BIRTHPLACE (City and State or Foreign Country): BOGGSTOWN, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1951
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 5117 JEFFERSON STREET
9c. CITY, TOWN OR LOCATION OF DEATH: GARY
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CAROL HARRINGTON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): AUTO/TRUCK MECHANIC
12b. KIND OF BUSINESS/INDUSTRY: WAYNE'S FRAME & BODY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 5117 JEFFERSON STREET
13e. ZIP CODE: 46408
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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): ROBERT FULTON
19. MOTHER'S NAME (First Middle Maiden Surname): EDITH SCOTT

INFORMANT

tax mailing address →

20a. INFORMANT'S NAME (Type/Print): CAROL FULTON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5117 JEFFERSON ST, GARY, IN 46408
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 5, 1993 NORTHWEST INDIANA CREMATION SERVICES
21c. LOCATION—City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO: 1010711
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gordon L Jones
24b. LICENSE NUMBER (of Licensee): 1010711
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home 10101 Broadway Crown Point, IN 46307 FDH83002445

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. Non-small cell lung cancer with liver and brain and bone metastasis
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.

FILED

PART II. Other significant conditions contributing to death but not previously stated in Part I

APR 29 1994

[signature] AUDITOR LAKE COUNTY

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): N/A

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
94 APR 29 AM 8 51
SAMUEL ORLICH RECORDER

94032429

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: P Tara MD
29c. MEDICAL LICENSE NO: 01031667
29d. DATE SIGNED (Month Day Year): 6/3/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Pimpa J. Tara, 8127 Merrillville Road, Merrillville, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): JUN 04 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

600

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD

01922