1

26-04-60

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 3198-91 ..... State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Charles R. Hamilton
2 SEX: Male
3a TIME OF DEATH: 12:50 A.M.
3b DATE OF DEATH (Month, Day, Yr.): December 20, 1991
4 SOCIAL SECURITY NUMBER: 422-28-1379
5a AGE—Last Birthday (Years): 62
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr.): Mar. 31, 1929
7 BIRTHPLACE (City and State or Foreign Country): Franklin County, AL.
8a WAS DECEDENT A U.S. VETERAN?: YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1950
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): Our lady of Mercy Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Nancy Gray
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Electrical Maintenance
12b KIND OF BUSINESS/INDUSTRY: Steel Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Griffith
13d STREET AND NUMBER: 834 S. Cline
13e ZIP CODE: 46319
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): Thomas Hamilton
19 MOTHER'S NAME (First, Middle, Maiden Surname): Flossie Whitlock

INFORMANT

20a INFORMANT'S NAME (Type/Print): Nancy Hamilton
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 834 S. Cline Griffith, Indiana
20c Relationship: Wife

DISPOSITION

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): December 23, 1991 Oakland Memory Lane
21c LOCATION—City or Town, State: Bolton, Illinois
22a EMBALMER'S NAME: Ronald A. Reed
22b EMBALMER'S LICENSE NO.: FDO 1001081
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: A. Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinmann Highland, Indiana FDH 300-7500

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. Sudden Cardiac Death
DUE TO (OR AS A CONSEQUENCE OF): b. End Stage Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF): c. Idiopathic Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last

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

27. WAS DECEDENT PREGNANT OR WITHIN 90 DAYS POSTPARTUM? (Yes or no): NO
28. AUTOPSY? (Yes or no): NO
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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

FEB 01 1995

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
FEB 1 1995
SAM ORLICH
AUDITOR LAKE COUNTY

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: [signature] MD
29c. MEDICAL LICENSE NO.: 000476
29d. DATE SIGNED (Month, Day, Year): 12/20/91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 231 Joliet Street Dyer, IN 46311

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): December 20, 199

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.

000062 6.00

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

MARGARETTE N. CLEVELAND
LAKE COUNTY RECORDER
95005658
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 FEB -1 PM 10:28