IDC 42 VRS RETURN TO: Thelma Hurt

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 2078-88 2801 N. KASTER CT MUNCIE IN 47304

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME First	Middle	Last	2 SEX	3 DATE OF DEATH (Mo Day Yr)
Abner	V	Hurt Jr	Male	September 20, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5d UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
352-10-0375	71			5-10-1917	Harrisburg, Arkansas

8 YEAR LAST SERVED IN U.S. ARMED FORCES: 1943

8a PLACE OF DEATH (Check only one. See instructions.)
HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA
OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

8b FACILITY NAME (If not institution give street and number)	8c CITY TOWN OR LOCATION OF DEATH	8d COUNTY OF DEATH
Methodist Hospital Southlake	Merrillville	Lake

9 MARITAL STATUS—Married Never Married Widowed Married (Now)	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	Thelma Chrystal	Laborer	Knox-Foundry

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	4130 W. 20th Place

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban Mexican Puerto Rican etc)	15 RACE—American Indian Black White etc (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
Yes	NO	46404	☒ No ☐ Yes Specify	Black		

PARENTS

17 FATHER'S NAME (First Middle Last): Abner V. Hurt Sr

18 MOTHER'S NAME (First Middle Maiden Surname): Mary Jane Horne

INFORMANT

19a INFORMANT'S NAME (Type/Print): Thelma Hurt

19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 4130 W. 20th Place Gary, IN 46404

19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 24, 1988 Evergreen Cemetery

20c LOCATION—City or Town State: Hobart, Indiana

21a SIGNATURE OF FUNERAL DIRECTOR: Patricia Dove

21b LICENSE NUMBER (Year Licensed): 8700298

22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL DIRECTOR: Guy & Allen Funeral Directors INC 2959 W. 11th Ave Gary, IN 47704

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge death occurred at the time date and place stated. Signature and Title

23b LICENSE NUMBER

23c DATE SIGNED (Month Day Year)

ITEMS 24-29 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 8:02 P.M.

25 DATE PRONOUNCED DEAD (Month Day Year): September 20, 1988

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH

PART I Enter the diseases injuries or complications that caused the death Do not enter the mode of dying such as cardiac or respiratory arrest shock or heart failure List only one cause on each line

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute cerebrovascular accident

DUE TO (OR AS A CONSEQUENCE OF)

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

Sequentially list conditions if any leading to immediate cause Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death: days

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Respiratory failure

27 WAS AN AUTOPSY PERFORMED? No

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

SEE INSTRUCTIONS

CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge death occurred due to the cause(s) and manner as stated

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated

29a SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month Day Year)
Michael Kowalski MD	01033371	9-29-88

29e NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 300 E 86th Pl Merrillville In. 46410 Michael Kowalski MD

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Paul A Johnson MD

32 DATE FILED (Month Day Year): 10/7/88

CORONER OR MEDICAL EXAMINER 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)

SBH06-004 State Form 10110 Rev 10/87 DEATH-PD 1

ADDITION

1ST

THIRTY TWO

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#47-444-13