C95-3088

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2276-93 .... State No. ....

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): Jerry W. Bolton
2. SEX: Male
3a. TIME OF DEATH: 04:09A M
3b. DATE OF DEATH (Month, Day, Yr): September 24, 1993
4. SOCIAL SECURITY NUMBER: 401-60-0959
5a. AGE—Last Birthday (Years): 50
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Jan 21, 1943
7. BIRTHPLACE (City and State or Foreign Country): Island, KY
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1964
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): 7285 Laurel Ln.
9c. CITY, TOWN OR LOCATION OF DEATH: Lowell
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Holly Townsley
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Superintendant
12b. KIND OF BUSINESS/INDUSTRY: Assembly Plant
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Lowell
13d. STREET AND NUMBER: 7285 Laurel Ln.
13e. ZIP CODE: 46356
13f. INSIDE CITY LIMITS: ☐ No ☑ Yes
13g. ON A FARM?: ☑ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Paul W. Bolton
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Caldwell

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Holly Bolton
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Lowell, IN 46356
20c. Relationship:

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): Sep 27, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, IN
22a. EMBALMER'S NAME: Kenneth P. Sheets
22b. EMBALMER'S LICENSE NO.: FD08900045
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD08900045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, FD83004277, 604 E. Commercial Ave., Lowell, 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. primary brain tumor - s/p blastoma
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 stated in Part I: convulsion

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?
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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 5000 2521
29d. DATE SIGNED (Month, Day, Year): 9-27-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Randall Hile MD, 1020 E. Commercial Ave., Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): 9/27/93

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) If yes, specify driver, passenger, pedestrian, etc.

000427

SEP 27 1993

I HEREBY CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL ON FILE IN THE LAKE COUNTY HEALTH DEPARTMENT — Alexander S. Williams, LAKE COUNTY HEALTH COMMISSIONER

95 SEP -7 PM

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD — MARGARET ... RECORDER

95052718

FILED SEP 7 1995 SAM ORLICH AUDITOR LAKE COUNTY

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