16cv 126 Carl C. Thornberry 1632 W. 40th Ave, Gary In 46408

INDIANA STATE BOARD OF HEALTH

Local No. 88-0588

CERTIFICATE OF DEATH

State No. 1988

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Month Day Year)
Ann	Beryl	Thornberry	Female	August 27, 1988

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 (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
273-28-9760	61			9-24-1926	England

8 YEAR LAST SERVED IN U.S. ARMED FORCES? NONE

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)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Northlake Methodist Hospital	Gary	Lake

10 MARITAL STATUS—Married Never Married Widowed Divorced (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	Carl Thronberry	Home Maker	Self

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
46408	Lake	Gary, Indiana	1632 West 40th Ave

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) Specify	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		☐ No ☐ Yes	White	12	

PARENTS

17 FATHER'S NAME (First Middle Last)	18 MOTHER'S NAME (First Middle Maiden Surname)
Arthur Naden	

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	19c Relationship
Carl Thronberry	1632 West 40th Ave Gary, Indiana 46408	Husband

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	20c LOCATION—City or Town State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	August 31, 1988 Evergreen Memorial Park	Hobart, Indiana

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Robert Wiatrolik	FDE1001293	Stilinovich & Wiatrolik-FDH1004455 7535 Taft St., Merrillville, IN

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 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month Day Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
08:24P	August 27, 1988	NO

CAUSE OF DEATH

27 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

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac arrest — minutes
DUE TO (OR AS A CONSEQUENCE OF)
b. Cardiac arrest — minutes
DUE TO (OR AS A CONSEQUENCE OF)
c. Congestive heart failure — 9 months
DUE TO (OR AS A CONSEQUENCE OF)
d.

SEE INSTRUCTIONS

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

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

	28 WAS AN AUTOPSY PERFORMED? (Yes or no)	29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Diabetes mellitus Renal insufficiency	NO	

SEE INSTRUCTIONS

29a 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 to cause of death) To the best of my knowledge death occurred at the time, date, and place stated 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

CERTIFIER

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month Day Year)
Michael Kovacich MD	0103371	8-29-88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Dr. Michael Kovacich, 206 East 86th Ave, Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Thomas T. Hedrick Jr M	AUG 29 1988

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)

3364

Addition to Grant Terrace lot 28 unit 01 Key #39-437-28

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD SEP 25 9:26 MORGAN TILLMAN RECORDER

FILED SEP 26 1996

SAM ORLICH AUDITOR LAKE COUNTY