Local No. 1 3135-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (FIRST, MIDDLE, LAST): IDA B. THOMAS
2. SEX: F
3. DATE OF DEATH (Mo. Day, Yr.): JUNE 14, 1989
4. SOCIAL SECURITY NUMBER: 314-72-9083
5a. AGE—Last Birthday (Years): 86
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): 1-28-04
7. BIRTHPLACE (City and State or Foreign Country): BIRMINGHAM, ALA.
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: NO
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): MERRILLVILLE CONVALESCENT CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): WILLIAM THOMAS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: GARY
13d. STREET AND NUMBER: 2152 HAYES STREET
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46404
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): BLACK
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): THOMAS JENKINS
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA JENKINS

INFORMANT

19a. INFORMANT'S NAME (Type/Print): REV. WILLIAM THOMAS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2152 HAYES ST. GARY, INDIANA
19c. Relationship: HUSBAND

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): JUNE 19, 1989-EVERGREEN PARK
20c. LOCATION—City or Town, State: HOBART, INDIANA
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): 01012357
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANDREW SMITH FUNERAL HOME 934 E. 21ST. AVE.-8300650 GARY, INDIANA

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: [signature]
23b. LICENSE NUMBER: 15767
23c. DATE SIGNED (Month, Day, Year): 6-23-89

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

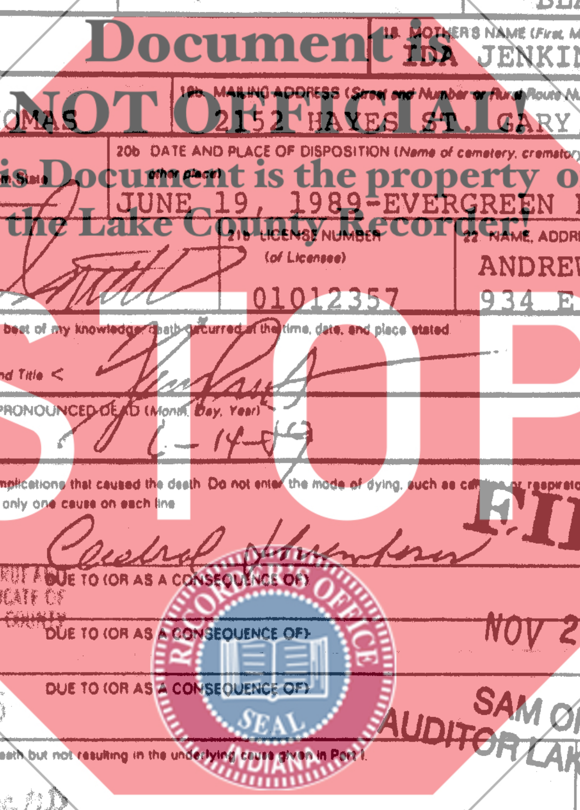
24. TIME OF DEATH: 7 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): 6-14-89
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

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. Cerebral Hemorrhage [handwritten]
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): no
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):



I CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF ... LAKE COUNTY
[signature] LAKE COUNTY HEALTH COMMISSIONER
NOV 20 1995
FILED
NOV 20 1995
SAM ORLICH
AUDITOR LAKE COUNTY
RECORDER'S OFFICE SEAL INDIANA
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
95070783
NOV 20 AM 11:18
RECORDER

CERTIFIER (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 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

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 15767
29d. DATE SIGNED (Month, Day, Year): 6-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Jacob E. Pruitt, MD 7825 Broadway Merrillville IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): June 27, 1989

CORONER OR MEDICAL EXAMINER USE ONLY

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):

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SBH06-004 State Form 10110 (R/10-87) DEATH/PD 1 Terry Gray 2210 W. 11th AVE GARY 46404