[redacted]

89-0864

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ALBERT THOMAS
2 SEX: MALE
3a TIME OF DEATH: 8:26 a M
3b DATE OF DEATH (Month, Day, Yr): December 14, 1989
4 SOCIAL SECURITY NUMBER: 380222262
5a AGE—Last Birthday (Years): 66
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day, Yr): Mar 26, 1923
7 BIRTHPLACE (City and State or Foreign Country): MISSISSIPPI
8a WAS DECEDENT A U.S. VETERAN? NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL NORTHLAKE
9c CITY, TOWN, OR LOCATION OF DEATH: GARY
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): Ruby Thomas
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life): SELF-EMPLOYED
12b KIND OF BUSINESS/INDUSTRY: FREEWAY GAS STATION
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: GARY
13d STREET AND NUMBER: 1801 W. 17TH AVENUE
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify): BLACK
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th; College (1-4 or 5+): 0

PARENTS

18 FATHER'S NAME (First, Middle, Last): PETE THOMAS
19 MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE MCKINLEY

INFORMANT

20a INFORMANT'S NAME (Type/Print): RUBY THOMAS
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1801 W. 17TH AVE, GARY, IN 46404
20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 12/19/89, ~~OAK HILL~~ Evergreen CEMETERY
21c LOCATION—City or Town, State: Hobart Indiana
22a EMBALMER'S NAME: PATRICIAN OWENS
22b EMBALMER'S LICENSE NO.: 08700298
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Valerie J Broadway
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen, 2959 W. 11th Ave, 8300770

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
96 FEB 22 PM 2:34
MARY VELTRI CLEVELAND RECORDER

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. Severe end stage cardiomyopathy
b. DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. c. DUE TO (OR AS A CONSEQUENCE OF): Cardiac arrhythmia
d. DUE TO (OR AS A CONSEQUENCE OF): gangrene of lower extremities, renal failure

FILED

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

FEB 22 1996

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
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

SAM ORLICH AUDITOR LAKE COUNTY

29b SIGNATURE AND TITLE OF CERTIFIER: Vurkna Gupta
29c MEDICAL LICENSE NO.: 01030560
29d DATE SIGNED (Month, Day, Year): 12/19/89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Garlapati, 6111 Harrison St. Merrillville, IN.

HEALTH OFFICER

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

Key # 43-170-1

CORONER 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):
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

001194

9285