Northwest Indiana

Local No. 265

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

30-421-23

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)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Anderson	F.	Skinner	Male	8:45 A M	September 11, 1993

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 (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
427-80-2133	54			Sept. 2, 1939	Vaiden, Mississippi

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	----	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
4030 Alder Street	East Chicago	Lake

10 MARITAL STATUS (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	Ruthie Glover	Crane Mobile	Inland Steel

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	4030 Alder Street

13e ZIP CODE	13f INSIDE CITY LIMITS	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)
46321	☐ No ☒ Yes	U.S.A.	☒ No ☐ Yes	Black	Elementary/Secondary (0-12) 10th Grade; College (1-4 or 5 +)

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
George Skinner	Lillian Ward

INFORMANT

20a INFORMANT'S NAME (Type/print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Ruthie Skinner	4030 Alder St. East Chicago, Indiana	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION -City or Town State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	September 16, 1993 Fern Oaks Cemetery	Griffith, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Tracy Cheri Williams	FD08600238	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Tracy Cheri Williams	FD08600238	83001520 Hinton Williams Funeral Home 4859 Alexander, East Chicago IN 46312

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a Vascular collapse	Unknown
DUE TO (OR AS A CONSEQUENCE OF)	
b Due to arteriosclerotic heart and vascular disease	
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

FILED
FEB 26 1996
SAM OLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY RECORDER
FEB 29 AM 9:04
RECORDER

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

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	

FILE

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
Daniel D. Thomas	16120	September 15, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
Dr Jane Ann Kozlowski	9-17-93

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	011274

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc
September 11, 1993	

{#0488-13711 #0488-13791}

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1