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PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Ambers Carr
2. SEX: Male
3a. TIME OF DEATH: 1:30p M
3b. DATE OF DEATH (Month Day Yr): January 11, 1993
4. SOCIAL SECURITY NUMBER: 406-03-3618
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr): March 25, 1920
7. BIRTHPLACE (City and State or Foreign Country): Allen, Kentucky
8a. WAS DECEDENT A U.S. VETERAN?: yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
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): Canterbury Place
9c. CITY, TOWN OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Porter
13c. CITY, TOWN OR LOCATION: Valparaiso
13d. STREET AND NUMBER: Canterbury Place
13e. ZIP CODE: 46383
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): na; College (1-4 or 5+): na

PARENTS

18. FATHER'S NAME (First Middle Last): Nathan Carr
19. MOTHER'S NAME (First Middle Maiden Surname): Ellen Conn

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Marie Lewis
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Lake Station, In. 46405
20c. Relationship: Friend

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January13, 1993 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, In.
22a. EMBALMER'S NAME: No Embalming
22b. EMBALMER'S LICENSE NO.: None
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Philip F Angel
24b. LICENSE NUMBER (of Licensee): FD09900224
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Engel Funeral Home FDH3007893 2700 Willowcreek Portage, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiorespiratory Failure — Approximate Interval Between Onset and Death: Minutes
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial Infarction — Minutes
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 pregnancy related in Part I.
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): 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: Kallan
29c. MEDICAL LICENSE NO.: 01037891
29d. DATE SIGNED (Month, Day, Year): 2-5-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Nazzari M.D. Demotte Medical Center Demotte IN 46310

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Balcita MD
32. DATE FILED (Month, Day, Year): February 8, 1993

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

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L. Ryan 2nd Sub

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

MARY ... RECORDER

960 ... 710

FILED AUG ... 1996

SAM ORLICH AUDITOR LAKE COUNTY

Chicago Title Insurance Company

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