10cc

Local No. 935

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

NOV 30 1991 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Ethel Lorraine Springfield
2 SEX: Female
3a TIME OF DEATH: 5:30 A.M.
3b DATE OF DEATH (Month Day Yr): November 12, 1991
4 SOCIAL SECURITY NUMBER: 310-44-4879
5a AGE—Last Birthday (Years): 49
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): November 12, 1942
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
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): St. Margarets Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): James A. Springfield
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Recorder
12b KIND OF BUSINESS/INDUSTRY: Inland Steel Corp.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 550 Clinton Street
13e ZIP CODE: 46406
13f INSIDE CITY LIMITS: XX Yes
13g ON A FARM?: XX No
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): 12th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Clarence E. Jennings
19 MOTHER'S NAME (First Middle Maiden Surname): Juanita E. Tarleton

INFORMANT

20a INFORMANT'S NAME (Type/Print): James A Springfield
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 550 Clinton Street Gary, Indiana 46406
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): November 16, 1991 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?: XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary, IN 46404

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. Anoxic Encephalopathy
b. DUE TO (OR AS A CONSEQUENCE OF): Respiratory Failure
c. DUE TO (OR AS A CONSEQUENCE OF): Severe Pneumonia
d. DUE TO (OR AS A CONSEQUENCE OF): E.N.D. Stage Renal Disease

Conditions if any which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

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): 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.
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 848
29d DATE SIGNED (Month Day Year): November 16, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Mischel, D.O. 5454 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month Day Year): NOV 20 1991

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

Stamps: FILED FEB 10 1997 SAM ORLICH AUDITOR LAKE COUNTY 000121

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 0089 [illegible] PM 3:05 MORRIS W. CARTER RECORDER

Ref # 43-86-23

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