

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 630-88

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME FIRST MIDDLE LAST MITCHELL LEON SHARPE			2 SEX Male	3 DATE OF DEATH (Mo Day Yr) March 22, 1988	
4 SOCIAL SECURITY NUMBER 414-05-9134	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) Apr. 1, 1914	
8 YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9c FACILITY NAME (if not institution give street and number) Methodist Hospital-Southlake Campus		9b 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) Clara Ostrowski	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use "retired") Boilermaker		12b KIND OF BUSINESS/INDUSTRY Construction	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Calumet Township	13d STREET AND NUMBER 3224 West 64th Avenue		
13e INSIDE CITY LIMITS? (Yes or no) Yes	13f FARM No	13g ZIP CODE 46408	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban Mexican Puerto Rican, etc) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify	15 RACE—American Indian Black White, etc (Specify) White	
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					
17 FATHER'S NAME (First Middle Last) Garfield Sharpe		18 MOTHER'S NAME (First Middle Modern Surname) Mary Hatmaker			
19a INFORMANT'S NAME (Type/Print) Clara Sharpe		19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3224 W. 46th Ave. Gary, IN 46408		19c Relationship wife	
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place) March 25, 1988 Calumet Park Cemetery		20c LOCATION—City or Town State Merrillville, Indiana	
21a SIGNATURE OF FUNERAL DIRECTOR 		21b LICENSE NUMBER (of Licensee) 1009893	22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROTHERS FUNERAL SERVICE 3002453 6360 Broadway, Merrillville, Indiana 46410		
23a To the best of my knowledge death occurred at the time, date and place stated Signature and Title < 		23b LICENSE NUMBER	23c DATE SIGNED (Month Day Year)		
24 TIME OF DEATH 8:57 AM		25 DATE PRONOUNCED DEAD (Month Day Year) March 22, 1988		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No	
27 PART I: Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Coronary Thrombosis		DUE TO (OR AS A CONSEQUENCE OF)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days	
Sequentially list conditions if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.		DUE TO (OR AS A CONSEQUENCE OF)			
PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		DUE TO (OR AS A CONSEQUENCE OF)			
28a CERTIFIER (Check only one) <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <input type="checkbox"/> 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 LICENSE NUMBER 17755		29c DATE SIGNED (Month Day Year) 3/23/88	
29a SIGNATURE AND TITLE OF CERTIFIER 		29c DATE SIGNED (Month Day Year) 3/23/88			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Seymour Oberlander, M.D. 3290 Grant Street, Gary, Indiana 46408					
31 HEALTH OFFICER'S SIGNATURE 				32 DATE FILED (Month Day Year) 3-23-88	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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)		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

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

SEE INSTRUCTIONS

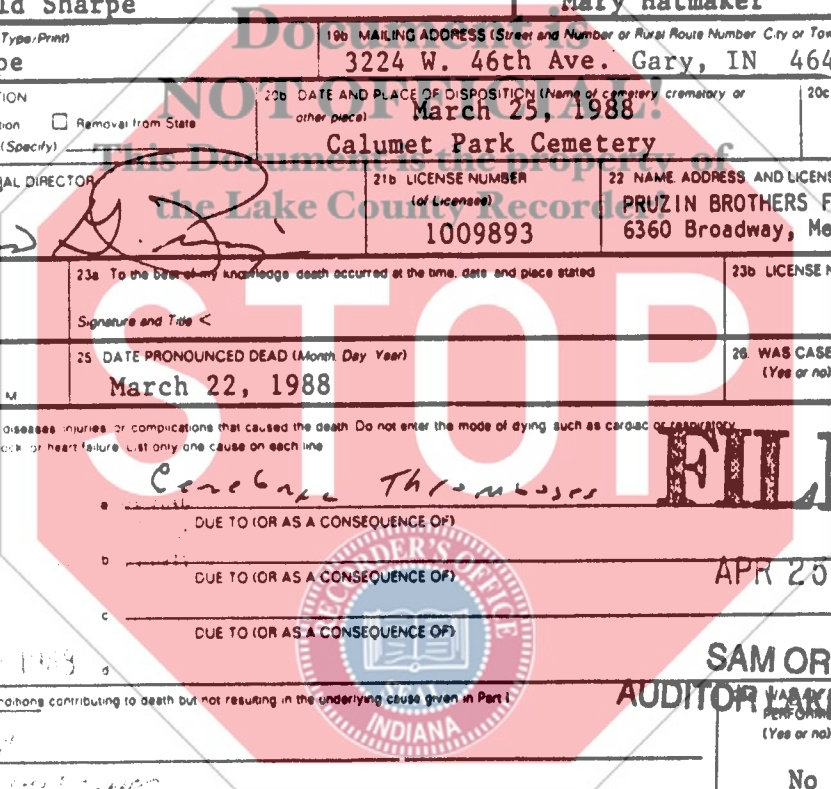
CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY



FILED
APR 25 1997
SAM ORLICH
AUDITOR LAKE COUNTY INDIANA
STATE OF INDIANA
LAKE COUNTY
RD
97 MAR 23 1988
REC'D DEPT. OF HEALTH
17755

DJ 9:00
ck 7419