

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1062-92

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) WILLIAM RONALD HILL
2 SEX Male
3a TIME OF DEATH 1:55 P M
3b DATE OF DEATH (Month, Day, Year) May 12, 1992
4 SOCIAL SECURITY NUMBER 305-44-2589
5a AGE—Last Birthday (Years) 47
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo, Day, Yr) September 12, 1944
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1971
8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL [ ] Inpatient [ ] ER/Outpatient [ ] OOA [ ] OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

DECEDENT

9a FACILITY NAME (If not institution, give street and number) Community Hospital
9b CITY, TOWN, OR LOCATION OF DEATH Munster
9c COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) married
11 SURVIVING SPOUSE (If wife, give maiden name) Jacqueline Eder
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Police Officer
12b KIND OF BUSINESS/INDUSTRY Hammond Police Dept.
13a RESIDENCE—STATE Indiana
13b COUNTY Lake
13c CITY, TOWN, OR LOCATION Hammond
13d STREET AND NUMBER 7019 Ridgeland Avenue
13e ZIP CODE 46324
13f INSIDE CITY LIMITS [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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) 12 College (1-4 or 5+) 2

PARENTS

18 FATHER'S NAME (First, Middle, Last) William Clay Hill
19 MOTHER'S NAME (First, Middle, Maiden Surname) Martha Mary Chupp

INFORMANT

20a INFORMANT'S NAME (Type/Print) Jacqueline Hill
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7019 Ridgeland Ave., Hammond, Ind. 46324
20c Relationship Wife

DISPOSITION

21a METHOD OF DISPOSITION [X] Burial [ ] Entombment [ ] Cremation [ ] Removal from State [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 16, 1992 St. Joseph Cemetery
21c LOCATION (City or Town, State) Hammond, Indiana

CAUSE OF DEATH

22a EMBALMER'S NAME Charles W. Wells
22b EMBALMER'S LICENSE NO # 1042372
23 WAS DEATH REPORTED TO CORONER? [ ] No [X] Yes

24a SIGNATURE OF FUNERAL DIRECTOR John A. Boyer
24b LICENSE NUMBER (of Licensee) FD# 1007231
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Solan Funeral Home FH # 3302893 7109 Calumet Ave., Hammond, Ind. 46324

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. Occlusive coronary arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF)
b.
c.
d.
Approximate Interval Between Onset and Death Unknown
FILED OCT 21 1997

CERTIFIER

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
28 AUTOPSY FINDINGS (Yes or no) Yes
29a CERTIFIER (Check only one) [ ] CERTIFYING PHYSICIAN [ ] HEALTH OFFICER [X] CORONER
29b SIGNATURE AND TITLE OF CERTIFIER Daniel D. Thomas, M.D., Coroner
29c MEDICAL LICENSE NO 16120
29d DATE SIGNED (Month, Day, Year) May 14, 1992

HEALTH OFFICER

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
31 HEALTH OFFICER'S SIGNATURE Alexander S. Williams, MD
32 DATE FILED (Month, Day, Year) May 14, 1992

CORONER USE ONLY

33 MANNER OF DEATH [X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Homicide
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED: DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
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) May 12, 1992
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian. Alexander S. Williams, MD LAKE COUNTY HEALTH COMMISSIONER