Local No. 770-90

INDIANA STATE BOARD OF HEALTH

50-142-9

CERTIFICATE OF DEATH

State No.

Patricia Bell 2682 Vigo Lake Station IN. 46405

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	J. B. Dobson
2. Sex	Male
3a. Time of Death	9:00 P.M.
3b. Date of Death (Month, Day, Yr)	March 29, 1990
4. Social Security Number	400-50-7119
5a. Age—Last Birthday (Years)	51 yrs.
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	10/31/38
7. Birthplace (City and State or Foreign Country)	Kentucky
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	None
9a. Place of Death (Check only one. See instructions)	Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. Facility Name (If not institution, give street and number)	St. Mary Medical Center
9c. City, Town, or Location of Death	Hobart, IN
9d. County of Death	Lake
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	Susan Conley
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Blast Furnace
12b. Kind of Business/Industry	Steel Mill
13a. Residence—State	IN.
13b. County	Lake
13c. City, Town, or Location	Lake Station
13d. Street and Number	2747 Utah St.
13e. Zip Code	46405
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	U.S.A.
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	Unavailable

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	Beckman Dobson
19. Mother's Name (First, Middle, Maiden Surname)	Maggie Fugate

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Susan Dobson
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2747 Utah St., Lake Station, IN 46405
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☒ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	APRIL 2 1990 — Dobson Cemetery
21c. Location—City or Town, State	Vest (Knott) KY
22a. Embalmer's Name	Roger A. Young
22b. Embalmer's License No.	FDO 8601323
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Roger A Young
24b. License Number (of Licensee)	FDO 8601323
25. Name, Address, and License Number of Funeral Home	Young Funeral Home-FH83001643 1307 Central Ave., Lake Station, IN 46405

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.

	Cause	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Lung Cancer, Respiratory Failure	
Due to (or as a consequence of) b.		
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 previously stated in Part I

Field	Entry
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.

Field	Entry
29b. Signature and Title of Certifier	[signature]
29c. Medical License No.	01027933
29d. Date Signed (Month, Day, Year)	4-4-90
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Shreyas A. Desai M.D. 804 Glendale Blvd. Valpo., IN 46383

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Paul A Johnson MD
32. Date Filed (Month, Day, Year)	April 5, 1990

CORONER USE ONLY

Field	Entry
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, etc.	

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 1990 MAR 29 PM 2:01 [stamp]

FILED OCT 29 1997

SAM ORLICH
AUDITOR LAKE COUNTY

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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