INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

STATE OF INDIANA
COUNTY
FILE NUMBER RECORD

Local No. 92-3014

State No. 98027400

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Henry Thedford
2 SEX: Male
3a TIME OF DEATH: 1:00 p.m.
3b DATE OF DEATH (Month, Day, Yr.): January 9, 1992
4 SOCIAL SECURITY NUMBER: 425-10-2584
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr.): August 14, 1910
7 BIRTHPLACE (City and State or Foreign Country): Livington, Al.
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): 2506 East 22nd Ave.
9c CITY, TOWN, OR LOCATION OF DEATH: Gary
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Mary Evans
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Rail Chipper
12b KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2506 East 22nd Ave.
13e ZIP CODE: 46407
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): David Thedford
19 MOTHER'S NAME (First, Middle, Maiden, Surname): Lizzie Holtz

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Thedford
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2506 East 22nd Ave. Gary, IN. 46407
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 14, 1992 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a EMBALMER'S NAME: Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO: 01051696
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Valerie Brodnax
24b LICENSE NUMBER (of Licensee): 08700646
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 8300770 Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary, Indian 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 congestive cardiac failure
Due to (or as a consequence of): b arteriosclerotic heart disease
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: Due to (or as a consequence of): c emphysema arteriosclerosis
d

Approximate Interval Between Onset and Death:

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Degenerative arthritis D. Heler Mellitus

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) and manner 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] for Dr. Potti
29c. MEDICAL LICENSE NO: IN 25043
29d. DATE SIGNED (Month, Day, Year): 1/16/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): K Krishnan for Dr. Potti 8300 Broadway Merrillville IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Rebecca E Foster MD MPH

FILED
JAN 21 1992

32. DATE FILED (Month, Day, Year):

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a DATE OF INJURY (Month, Day, Year): APR 17 [illegible]
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): SAM ORLICH EDITOR LAKE COUNTY
34g DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

001206

SBH06-004 State Form 10410 (R2/3-89) DEA CERT PD