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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 93-0750 ..... CERTIFICATE OF DEATH ..... State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Jerald D. Wright — 9804055
2. SEX: Male
3a. TIME OF DEATH: 4:55 A M
3b. DATE OF DEATH (Month, Day, Yr): October 6, 1993
4. SOCIAL SECURITY NUMBER: 306-34-5902
5a. AGE—Last Birthday (Years): 58
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): Nov. 4, 1934
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?: 1958
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): 2358 Hobart st.
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): Betty Flynn
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b. KIND OF BUSINESS/INDUSTRY: Union
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2358 Hobart St.
13e. ZIP CODE: 46406
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? ☒ 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): 7; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Wright
19. MOTHER'S NAME (First, Middle, Maiden Surname): Magdaline H. Wild

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Betty Wright
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2358 Hobart St. Gary, Indiana
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): October 8, 1993 Fair Cemetery
21c. LOCATION—City or Town, State: North Liberty, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO: FDO 1016173
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: A Kuiper
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd Highland, Indiana FDH 300-7500

FILED JUN 01 1993

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. Lymphoma
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

Approximate Interval Between Onset and Death

SAM ORLICH
EDITOR LAKE COUNTY

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: R S Drasga
29c. MEDICAL LICENSE NO: 01031484
29d. DATE SIGNED (Month, Day, Year): October 7, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ray E. Drasga, 8127 Merrillville Rd., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): OCT. 0 8 1993

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, Town, State) COUNTY
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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