Local No. 1778-92

# INDIANA STATE BOARD OF HEALTH
## CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First Middle Last): 9804 Herbert R. Roach
2 SEX: Male
3a TIME OF DEATH: 11:01 AM
3b DATE OF DEATH (Month Day Yr): August 16, 1992
4 SOCIAL SECURITY NUMBER: 315-14-2303
5a AGE—Last Birthday (Years): 69
5b UNDER 1 YEAR (Months / Days) / 5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo Day Yr): March 24, 1923
7 BIRTHPLACE (City and State or Foreign Country): Logansport, Indiana
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
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): 248 Mary Street
9c CITY TOWN OR LOCATION OF DEATH: Dyer
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Lena Hilbert
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): General Turn Foreman
12b KIND OF BUSINESS/INDUSTRY: Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Dyer
13d STREET AND NUMBER: 248 Mary Street
13e ZIP CODE: 46311
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): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5 +):

**PARENTS**

18 FATHER'S NAME (First Middle Last): Harve Roach
19 MOTHER'S NAME (First Middle Maiden Surname): Elizabeth Friend

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Lena Roach
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 248 Mary Street, Dyer, Indiana 46311
20c Relationship: Wife

**DISPOSITION**

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): August 19, 1992 — St. Joseph Cemetery
21c LOCATION—City or Town State: Dyer, Indiana
22a EMBALMER'S NAME: Edward Mullaney
22b EMBALMER'S LICENSE NO: FD01007176
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Edward F. Mullaney
24b LICENSE NUMBER (of Licensee): FD01007176
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83001504 Fagen-Miller Funeral Gardens, INc. 1920 Hart Street, Dyer, Indiana 46311

**CAUSE OF DEATH**

26 PART I Enter the sequence of 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. Vascular collapse
DUE TO (OR AS A CONSEQUENCE OF):
Conditions if any which gave rise to the immediate cause stating the underlying cause last: b. Due to arteriosclerotic heart and vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: Unknown

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. Chief Deputy ☒ 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: Deborah Huseman
29c. MEDICAL LICENSE NO: N/A
29d. DATE SIGNED (Month Day Year): August 21, 1992

**HEALTH OFFICER**

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Deborah Huseman, Chief Deputy, 2293 North Street, Crown Point, Indiana 46307
31 HEALTH OFFICER'S SIGNATURE
32 DATE FILED (Month Day Year): August 21, 1992

FILED

**CORONER USE ONLY**

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year)
34b TIME OF INJURY
34c INJURY AT WORK?
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): August 16, 1992
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

SAM ORLICH AUDITOR LAKE COUNTY

9:00 AM CST

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