Local No. 181

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Key # 30-24-17

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Joseph Pentecoste Sr
2 SEX: Male
3a TIME OF DEATH: 5:45 AM
3b DATE OF DEATH (Month Day Yr): June 27, 1993
4 SOCIAL SECURITY NUMBER: 330-10-9240
5a AGE—Last Birthday (Years): 74
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day Yr): July 31,1918
7 BIRTHPLACE (City and State or Foreign Country): Selma, AL
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: None
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c CITY, TOWN OR LOCATION OF DEATH: East Chicago
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Divorced
11 SURVIVING SPOUSE (If wife, give maiden name): ————
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Professor
12b KIND OF BUSINESS/INDUSTRY: Indiana University
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: East Chicago
13d STREET AND NUMBER: 710 W. 144th St. (Lutricia Thomas)
13e ZIP CODE: 46312
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+

PARENTS

18 FATHER'S NAME (First, Middle, Last): Clarence J. Pentecoste
19 MOTHER'S NAME (First, Middle, Maiden Surname): Georgia Watson

INFORMANT

20a INFORMANT'S NAME (Type/Print): Maria Pentecoste Still
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5364 Angus Dr. Virginia Beach, VA
20c Relationship: Daughter

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): July 3, 1993 Holy Sepulchre Cemetery
21c LOCATION—City or Town, State: Worth, IL
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO: 1045964
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3002819 5840 Hohman Hammond, IN(For Gatling F.H./Chicago,IL)

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Idiopathic Pulmonary Fibrosis
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

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
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 01030852
29d DATE SIGNED (Month, Day, Year): June 30,1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Elliot Stokar 761 W. 45th St. [M]unster, IN 46321

FILED

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
JUN 12 [redacted]
32 DATE FILED (Month, Day, Year): 7-1-93

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

SAM ORLICH
AUDITOR LAKE COUNTY
9.00 CM
Cash
0041030

STATE OF INDIANA ... PM 2:04
58011

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1