

\* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

KEY# (26)-37-168-9

7019 ARIZONA

Local No. .... 54 .....

## CERTIFICATE OF DEATH

State No. .... 41M-46323 .....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

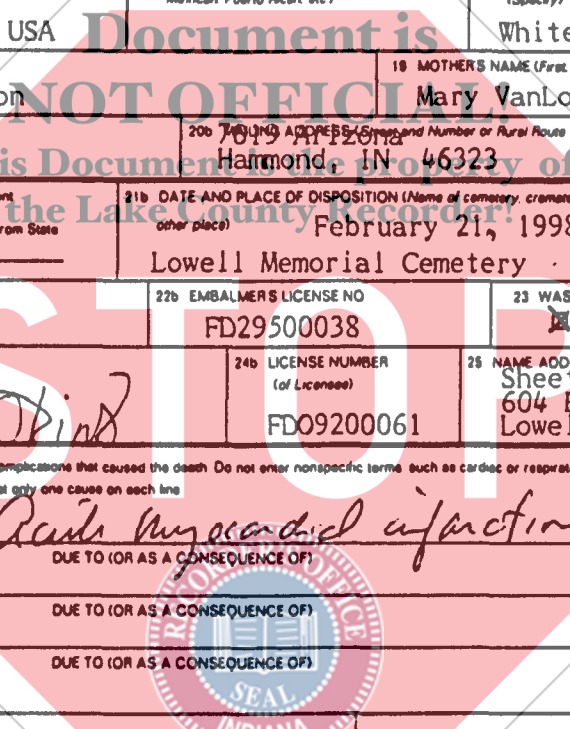
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Charles E. Johnson		2 SEX Male	3a TIME OF DEATH 02:24P <sub>M</sub>	3b DATE OF DEATH (Month, Day, Yr) February 18, 1998
4 *SOCIAL SECURITY NUMBER 313-36-4858	5a AGE—Last Birthday (Year) 58	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Sep 1, 1939
7 BIRTHPLACE (City and State or Foreign Country) IN	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) St. Catherines Hospital		9b CITY, TOWN, OR LOCATION OF DEATH East Chicago		9c COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Joyce Berg		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Railroad Car Repairman	
12b KIND OF BUSINESS/INDUSTRY Steel Mill		13a RESIDENCE—STATE IN		
13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7019 Arizona Ave.
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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 (9-12) 12 College (1-4 or 5+) 0		18 FATHER'S NAME (First, Middle, Last) Earl Edward Johnson		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary VanLoon		20a INFORMANT'S NAME (Type/Print) Joyce Johnson		
20b HOME ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7019 Arizona Hammond, IN 46323		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) February 21, 1998 Lowell Memorial Cemetery		21c LOCATION—City or Town, State Lowell, IN
22a EMBALMER'S NAME Byron G. Hawkins		22b EMBALMER'S LICENSE NO. FD29500038		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Molly E. Hawkins</i>		24b LICENSE NUMBER (of Licensee) FDO9200061		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home, #PH83004277 604 E. Commercial Ave. Lowell, IN
26 PART I. Enter the disease, 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) <i>Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)				
PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I. <i>coronary artery disease</i>				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a AUTOPSY PERFORMED? (Yes or no) N/A		28b COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>M. Silverman</i>		
29c MEDICAL LICENSE NO. 01035700		29d DATE SIGNED (Month, Day, Year) 2-23-98		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. M. Silverman, 6924 Indianapolis Blvd., Hammond, IN 46324				
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Raykowski</i>				32 DATE FILED (Month, Day, Year) 3-2-98
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.		34i		



FILED  
JUN 15 1998  
S.A.M. ORLICH  
CLERK OF SUPERIOR COURT  
LAKE COUNTY, INDIANA

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001146  
su  
CJ