

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH LAKE COUNTY

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 835

OCT 14 1988  
Date Issued  
Franklin D. Resnick, M.D.  
Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24 26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1 DECEASED—NAME FIRST MIDDLE LAST John Ennis			2 SEX Male	3 DATE OF DEATH (Mo. Day, Yr.) October 10th 1988
4 SOCIAL SECURITY NUMBER 306-36-8648		5a UNDER 1 YEAR 54 Months	5b UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) Feb. 28, 1934
8 YEAR LAST SERVED IN U.S. ARMED FORCES? 1955		7 BIRTHPLACE (City and State or Foreign Country) Hammond Indiana		
9a FACILITY NAME (If not institution, give street and number) 6851 Hohman Ave.				
10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify) Never Married		11 SURVIVING SPOUSE (If wife, give maiden name) None	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired") President of company	12b KIND OF BUSINESS/INDUSTRY Real Estate-Mortgage Banking-Insurance
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 6851 Hohman Ave.	
13e INSIDE CITY LIMITS? (Yes or no) Yes	13f FARM No	13g ZIP CODE 46324	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify: Cuban, Mexican, Puerto Rican, etc.) No	15 RACE—American Indian, Black, White, etc. (Specify) White
17 FATHER'S NAME (First, Middle, Last) Samuel C. Ennis		18 MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Loomis		
19a INFORMANT'S NAME (Type/Print) Nellie Ennis		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6847 Hohman Ave. Hammond Indiana	19c Relationship Mother	
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) October 15th 1988 Graceland Cemetery		20c LOCATION—City or Town, State Valparaiso Indiana
21a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		21b LICENSE NUMBER (of Licensee) 1013612	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 5713 Hohman Ave. Hammond IN 46320 McCoy Funeral Chapel 287	
23a To the best of my knowledge, death occurred at the time, date, and place stated Signature and Title < 23b LICENSE NUMBER		23c DATE SIGNED (Month, Day, Year)		
24 TIME OF DEATH 9:41 AM		25 DATE PRONOUNCED DEAD (Month, Day, Year) OCTOBER 10, 1988		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) Yes
27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying 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. <u>Acute Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>Pulmonary Embolism</u> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>Pulmonary Fibrosis - Recurrent Bacterial Pneumonia -</u> <u>Basal Cell Carcinoma -</u>				
28a WAS AN AUTOPSY PERFORMED? (Yes or no)		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <u>Edward M. ALT Jr. MD</u> 29c LICENSE NUMBER 18725 29d DATE SIGNED (Month, Day, Year) Oct. 10/14/1988		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <u>Edward M. ALT Jr. MD 7550 Hohman, Munster, Ind 46321</u>				
31 HEALTH OFFICER'S SIGNATURE <u>Franklin D. Resnick, M.D.</u>				32 DATE FILED (Month, Day, Year) OCT 14 1988
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED 9:00 a.m. UU1548 28356		