STATE OF INDIANA
STATE BOARD OF HEALTH
FILED FOR RECORD

CERTIFICATE OF DEATH

Local No. 185

State No. H-30-460-6

2000 014620

2000 MAR -1 PM 3:12

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Etwood Orville Smith
2. SEX: Male
3a. TIME OF DEATH: 3:05 A M
3b. DATE OF DEATH (Month, Day, Yr.): June 6, 1992
4. SOCIAL SECURITY NUMBER: 316-48-0849
5a. AGE—Last Birthday (Years): 47
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): June 17, 1945
7. BIRTHPLACE (City and State or Foreign Country): Cheyenne, Wyoming
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: ------
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): 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): Supervisor
12b. KIND OF BUSINESS/INDUSTRY: Omoco Oil Company
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 3915 Melville Ave.
13e. ZIP CODE: 46312
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 2 Years

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Smith
19. MOTHER'S NAME (First, Middle, Maiden Surname): Geraldine Johnson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Kevin Smith
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3915 Melville Ave. East Chicago, Indiana
20c. Relationship: Son

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): June 10, 1992 Fern Oaks Cemetery
21c. LOCATION—City or Town, State: Griffith, Indiana
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.: FD08600238
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John R. Williams
24b. LICENSE NUMBER (of Licensee): FD01041041
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home FH83001520 4859 Alexander Ave. East Chicago, In.

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. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF)
b. BRONCHIAL ASTHMA (CHRONIC)
DUE TO (OR AS A CONSEQUENCE OF)
c. EMPHYSEMA
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: CARDIAC ARRHYTHMIA CIGARETTE SMOKING

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no):
28a. WAS AN AUTOPSY PERFORMED? (Yes or no):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

FILED
MAR 01 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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: Michael D. Dawson MD
29c. MEDICAL LICENSE NO.: 01038891
29d. DATE SIGNED (Month, Day, Year): 6-11-92

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Michael A. Dawson 636 E 21st Ave Gary, IN 46407
31. HEALTH OFFICER'S SIGNATURE: Dr. Ignatius Rankovich
32. DATE FILED (Month, Day, Year): 6-12-92

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? (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): 6/6/92
34h. MOTOR VEHICLE ACCIDENT? (Yes or no): NO If yes, specify driver, passenger, pedestrian, etc.:

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

440 N. Parke St - P. O. Box 2655 · Gary, IN 46403