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Local No. 852-88

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED

State No. Key# 18-231-2

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME	First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
	RICHARD	G	WHITSON	MALE	APRIL 15, 1988

4. SOCIAL SECURITY NUMBER	5a. AGE—LAST BIRTHDAY (Years)	5b. IF UNDER 1 YEAR (Months / Days)	5c. IF UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
334-07-3132	77			OCT. 26, 1910	LOGAN, KANSAS

8. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
NO	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
1022 W. RIDGE ROAD	HOBART	LAKE

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	EVELYN BAHL	METALLURGICAL ENGINEER	UNION TANK CAR CO.

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
IND.	LAKE	HOBART	1022 W. Ridge Road

13e. INSIDE CITY LIMITS? (Yes or no)	13f. FARM	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
Yes	NO	46342		WHITE		

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
RICHARD WHITSON	ELORA FRANKLIN

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c. Relationship
EVELYN B. WHITSON	1022 W. Ridge Road, Hobart, IN 46342	WIFE

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	APRIL 18, 1988 CALVARY CEMETERY	PORTAGE, INDIANA

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James E. Burns	# 1374	BURNS FUNERAL HOME, 901 E. 7th, Hobart, IN 46342 #

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

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)
John O. Carter MD	AC 2643080	4/17/88

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
5:45 A.M.		

CAUSE OF DEATH

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. acute myocardial infarction	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension DUE TO (OR AS A CONSEQUENCE OF)	20 yr.
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d.	

SEE INSTRUCTIONS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. WAS AN AUTOPSY PERFORMED? (Yes or 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 (Physician certifying cause of death when another physician has pronounced death and completed items 23a-c) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John O. Carter MD	AC 2643080	4/17/88

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type/Print)	TELEPHONE NUMBER (Include Area Code)
JOHN O. CARTER, MD 295 South Wisconsin Street, Hobart, Indiana	942

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE

THIS CERTIFIES THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

32. DATE ISSUED (Month, Day, Year) 4-14-89

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				OCT 13 2000

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)

SBH06-004 State Form 10110 (R/10-87) DEATH A/PO 1

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