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Local No. 1828-92

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. 166-544

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	ROY H. SCHOON
2. SEX	MALE
3a. TIME OF DEATH	7:15A M
3b. DATE OF DEATH (Month, Day, Yr.)	AUGUST 30, 1992
4. SOCIAL SECURITY NUMBER	309-30-6907
5a. AGE—Last Birthday (Years)	61
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo., Day, Yr.)	Jul. 17, 1931
7. BIRTHPLACE (City and State or Foreign Country)	Highland, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1955
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	MUNSTER
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Betty Carlson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Hean Warehouseman
12b. KIND OF BUSINESS/INDUSTRY	Truck Terminal
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary (Calumet Township)
13d. STREET AND NUMBER	4413 Tompkins
13e. ZIP CODE	46408
13f. INSIDE CITY LIMITS	[X] No [ ] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8 /

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Peter Schoon
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Lillie Smith

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Betty Schoon
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4413 Tompkins Gary, Indiana
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	September 2, 1992 Ridgelawn Cemetery
21c. LOCATION—City or Town, State	[illegible], Indiana
22a. EMBALMER'S NAME	Edgar Gleim
22b. EMBALMER'S LICENSE NO.	FDO 1016173
23. WAS DEATH REFERRED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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FILED
MAY 6 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Lymphosarcoma	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

AUG 31 1992

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

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

CERTIFIER

29a. CERTIFIER (Check only one)

- [X] 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	27970
29d. DATE SIGNED (Month, Day, Year)	AUGUST 30, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	SALMAN D GAILANI, MD 9116 COLUMBIA AVENUE MUNSTER, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year)	August 31, 1992

CORONER USE ONLY

Field	Entry
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)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

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