Unit #24
Key # 30-11-3
Subd: SW S.28 T.37 R.9
Lot 14 Block 15

2611

HOWARD COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS IS AN OFFICIAL COPY OF THE RECORD OF DEATH ON FILE AT THE HOWARD COUNTY HEALTH DEPARTMENT.

ALAN J. ADLER, M.D., HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last): LILLIE M. CONWAY			2. SEX: FEMALE	3a. TIME OF DEATH: 12:00A	3b. DATE OF DEATH (Month, Day, Yr.): FEB.11,1998
4. *SOCIAL SECURITY NUMBER: 307-32-5332	5a. AGE—Last Birthday (Years): 65	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr): SEPT.21,1932	7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO,IND
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): 1908 TAM-O-SHANTER CT.			9c. CITY, TOWN, OR LOCATION OF DEATH: KOKOMO	9d. COUNTY OF DEATH: HOWARD	
10. MARITAL STATUS (Specify): WIDOWED	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): SCHOOL SECRETARY	12b. KIND OF BUSINESS/INDUSTRY: SCHOOL	
13a. RESIDENCE—STATE: INDIANA	13b. COUNTY: HOWARD	13c. CITY, TOWN, OR LOCATION: KOKOMO		13d. STREET AND NUMBER: 1908 TAM-O-SHANTER CT.	
13e. ZIP CODE: 46902	13f. INSIDE CITY LIMITS ☐ No ☐ Yes; 13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: U.S.A.	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): 12; College (1-4 or 5+): 0
18. FATHER'S NAME (First, Middle, Last): ARTHUR KING			19. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE L. SMITH		
20a. INFORMANT'S NAME (Type/Print): CHERYL C. GRIFFITH		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): FORT CAMPBELL,KY			20c. Relationship: DAUGHTER
21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB.14,98-CROWN POINT CEMT		21c. LOCATION—City or Town, State: KOKOMO,IND	
22a. EMBALMER'S NAME: NATHAN L. BLUITT		22b. EMBALMER'S LICENSE NO.: 1052943		23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR: Nathan L. Bluitt		24b. LICENSE NUMBER (of Licensee): 1052943		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 511 E.MONROE ST.KOKOMO,IN 46901 BLUITT FUNERAL HOME-3003881	

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. Thrombus of Coronary Artery
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
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

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	Yes	

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Jeffrey A Stout	NIA	2-16-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jeffrey A. Stout 1800 W. MARKLAND Kokomo

31. HEALTH OFFICER'S SIGNATURE: Alan J. Adler M.D.

32. DATE FILED (Month, Day, Year): FEB 16 1998

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				

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.

FILED
SEP 2 - 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR
000234

DH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

William A. Kowalski
4704 Indianapolis Blvd. East Chicago, IN. 46312