



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1497-93

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

DRONER  
E ONLY

1. DECEASED—NAME (First, Middle, Last) Sanford M. Tribble		2. SEX Male		3a. TIME OF DEATH 6:30 A M		3b. DATE OF DEATH (Month, Day, Yr) June 5, 1993	
4. SOCIAL SECURITY NUMBER 490-07-4323		5a. AGE—Last Birthday (Years) 80		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) March 6, 1913		7. BIRTHPLACE (City and State or Foreign Country) Hannibal, Missouri					
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: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 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) Geraldine G. Gibbons		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Welder		12b. KIND OF BUSINESS/INDUSTRY Railroad Car Manufactu	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Dyer		13d. STREET AND NUMBER 109 Carnation St.	
13e. ZIP CODE 46311		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8					
18. FATHER'S NAME (First, Middle, Last) Norman E. Tribble				19. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Routon			
20a. INFORMANT'S NAME (Type/Print) Geraldine G. Tribble				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Carnation St. Dyer, Indiana 46311		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) June 8, 1993 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Leonard Gregorczyk				22b. EMBALMER'S LICENSE NO. FDE 8800305		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mulligan</i>				24b. LICENSE NUMBER (of Licensee) FDE 1007176		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH83001504 Fagen-Miller Funeral Gardens Inc 1920 Hart St. Dyer, Indiana 46311	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) NOV 9 2004 a. <i>Pulmonary Embolism</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Chronic obstructive pulmonary Disease</i>							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No				28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <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) as stated. <input type="checkbox"/> 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 <i>Mohammed Y. Ali</i>				29c. MEDICAL LICENSE NO. 29782		29d. DATE SIGNED (Month, Day, Year) June 7, 1993	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Mohammed Y. Ali, M.D. 9116 Columbia Ave. Munster, IN 46321							
31. HEALTH OFFICER'S SIGNATURE <i>Mohammed Y. Ali, M.D.</i>						32. DATE FILED (Month, Day, Year) June 7, 1993	
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. 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.			