1 Key# 35-22518

Local No. 834

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Oct 9 1990 — Date Issued

[signature] — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): John Sadler

2 SEX: Male

3a TIME OF DEATH: 7:05 p. M

3b DATE OF DEATH (Month, Day, Yr): October 4, 1990

4 SOCIAL SECURITY NUMBER: 306-03-0787

5a AGE—Last Birthday (Years): 78

5b UNDER 1 YEAR (Months, Days):

5c UNDER 1 DAY (Hours, Minutes):

6 DATE OF BIRTH (Mo, Day, Yr): Aug. 5,1912

7 BIRTHPLACE (City and State or Foreign Country): Calumet, Michigan

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 ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Widowed

11 SURVIVING SPOUSE (If wife, give maiden name): None

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Lead Operator

12b KIND OF BUSINESS/INDUSTRY: Inland Steel Co.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Hammond(Whiting P.O.)

13d STREET AND NUMBER: 1541 Parkview Avenue

13e ZIP CODE: 46394

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): White

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Joseph Sadler

19 MOTHER'S NAME (First, Middle, Maiden Surname): Frances Vertin

INFORMANT

20a INFORMANT'S NAME (Type/Print): Miss Diane Sadler

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1541 Parkview, Whiting, IN 46394

20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 8,1990 St. John Cemetery

21c LOCATION—City or Town, State: Hammond, Indiana

22a EMBALMER'S NAME: Martin A. Dybel

22b EMBALMER'S LICENSE NO: FDE01019456

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FDE01019456

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc, FDH83007267 1235 119th, Whiting, IN 46394

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a Bronchogenic Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

b

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

Approximate Interval Between Onset and Death

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Pneumonia, Atrial Fibrillation

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): ---

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: [signature]

29c MEDICAL LICENSE NO.: 35185

29d DATE SIGNED (Month, Day, Year): Oct. 5-90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): O. Lee, M.D. 800 StateLine Avenue, Calumet City, Illinois 60409

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.

32 DATE FILED (Month, Day, Year): OCT 0 9 1990

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):

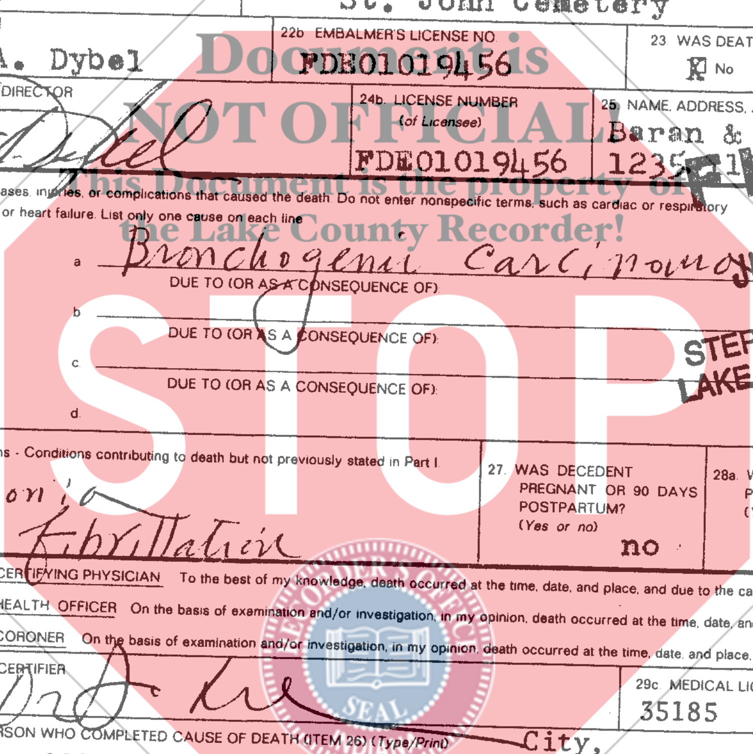
000601

34g DATE PRONOUNCED DEAD (Month, Day, Year):

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

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

Tax mail 1541 Parkview Ave Whiting, In 46394



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FILED JUN -7 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2005

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