Local No. 4170-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

8cc'p

MTL 1706LK05

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MARION S. CUNNINGHAM
2. SEX: Male
3a. TIME OF DEATH: 8:27A M
3b. DATE OF DEATH (Month, Day, Yr.): September 17, 1989
4. SOCIAL SECURITY NUMBER: 346-07-6385
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): JUL 6, 1914
7. BIRTHPLACE (City and State or Foreign Country): DANVILLE, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE CAMPUS
9c. CITY, TOWN, OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): FRIEDA SEEBAUER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LABORER
12b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 327 HUBER BOULEVARD
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN CUNNINGHAM
19. MOTHER'S NAME (First, Middle, Maiden Surname): ARTEA DHU

INFORMANT

20a. INFORMANT'S NAME (Type/Print): FRIEDA CUNNINGHAM
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 327 HUBER BOULEVARD, HOBART, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEP 21, 1989 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FD01004194
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gerald Rees
24b. LICENSE NUMBER (of Licensee): FD01041083
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME - FDH3003069, 600 W. OLD RIDGE RD, HOBART, IN 46342

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. Myocardial — 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: >1 hour

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

SEP 19 1989

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

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

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: T G Goodwin MD
29c. MEDICAL LICENSE NO.: 0101939
29d. DATE SIGNED (Month, Day, Year): 9/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): THOMAS G. GOODWIN MD, 6111 HARRISON STREET, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Carol Johnsonius
32. DATE FILED (Month, Day, Year): SEP 19, 89

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.:

FILED
JUN 27 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

02118

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