MEDICAL CERTIFICATE OF DEATH
MARION COUNTY HEALTH DEPARTMENT
222 EAST OHIO STREET
INDIANAPOLIS INDIANA 46204

Local No. .....

State No. .....

12CC/P

TYPE/PRINT IN PERMANENT BLACK INK

12CC

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
JAMES	A.	FLECK	Male	3:15P M	December 24, 1990

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
316-56-8200	39			MAY 17, 1951	GARY, INDIANA

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one See instructions)
No	N/A	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
METHODIST HOSPITAL OF INDIANA	INDIANAPOLIS	MARION

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	PHYLLIS HALFMAN	ELECTRICIAN	NIPSCO

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	HEBRON	596 WEST 30 SOUTH

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46341	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	WHITE	12	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
CARL FLECK SR.	RITA REARICK

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
PHYLLIS FLECK	596 WEST 30 SOUTH, HEBRON, IN 46341	Wife

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	DEC 29, 1990 CALVARY CREMATORY	PORTAGE, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FD01004194	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	FH83003069 REES FUNERAL HOME 600 W. OLD RIDGE RD. HOBART, IN 46342

MICHAEL B. BROWN RECORDER 2007 DEC 21 PM 2:45

CAUSE OF DEATH

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)

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

		Approximate Interval Between Onset and Death
a.	LIVER FAILURE (VENOOCCLUSIVE DISEASE)	2 WEEKS
	DUE TO (OR AS A CONSEQUENCE OF)	
b.	BONE MARROW TRANSPLANTATION	3 WEEKS
	DUE TO (OR AS A CONSEQUENCE OF)	
c.	CHRONIC MYELOGENOUS LEUKEMIA	4 1/2 YRS.
	DUE TO (OR AS A CONSEQUENCE OF)	
d.		

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)
N/A	No	N/A

FILED DEC 21 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Jansen MD	0100005	1/2/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29a) (Type/Print)

JAN JANSEN MD, 1633 N. CAPITOL AVE #300,, INDIANAPOLIS, IN 46202

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) JAN 0 8 1991

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.

24687

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

Parcel # 17-04-0007-0039