INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 536-90 State No. 45-09-31-102-040-000-018

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	EDWARD W. COLLINS
2. SEX	MALE
3a. TIME OF DEATH	8:15P M
3b. DATE OF DEATH (Month, Day, Yr)	APRIL 12, 1990
4. SOCIAL SECURITY NUMBER	304-14-9081
5a. AGE—Last Birthday (Years)	69
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	JULY 12, 1920
7. BIRTHPLACE (City and State or Foreign Country)	CINCINNATI, IOWA
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH	HOBART
9d. COUNTY OF DEATH	LAKE COUNTY
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	MYRTLE V. IHME
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	CRANE OPERATOR
12b. KIND OF BUSINESS/INDUSTRY	US STEEL
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HOBART
13d. STREET AND NUMBER	150 SOUTH COLORADO STREET
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	HERMAN COLLINS
19. MOTHER'S NAME (First, Middle, Maiden Surname)	MYRTLE SCOTT

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MYRTLE COLLINS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	150 SOUTH COLORADO ST, HOBART, IN 46342
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	APRIL 14, 1990 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State	SCHERERVILLE, 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	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	REES FUNERAL HOMES, INC. FDH3003069 600 W. RIDGE ROAD, 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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	CARCINOMA OF URINARY BLADDER WITH BRAIN METASTASES	1 YR
DUE TO (OR AS A CONSEQUENCE OF): b.		
DUE TO (OR AS A CONSEQUENCE OF): c.		
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.

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	NO
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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	B Barai
29c. MEDICAL LICENSE NO.	01030107
29d. DATE SIGNED (Month, Day, Year)	4/16/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	BHARAT BARAI, MD, 521 EAST 86TH AVENUE, SUITE C, MERRILLVILLE, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Paul A Johnson MD
32. DATE FILED (Month, Day, Year)	APR 16, 90

CORONER USE ONLY

Field	Entry
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)	
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

FILED SEP 08 2008 015629 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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