Local No. 0352-92 ..... G0094175

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Owen N. Murray
2. SEX: Male
3a. TIME OF DEATH: 3:00a.m.
3b. DATE OF DEATH (Month, Day, Yr.): February 3,1992
4. SOCIAL SECURITY NUMBER: 542-24-4741
5a. AGE—Last Birthday (Years): 61
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 18,1930
7. BIRTHPLACE (City and State or Foreign Country): Portland, Oregon
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1953
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 417 W. 75th Place
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): Shirley Ritchie
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steel Consultant
12b. KIND OF BUSINESS/INDUSTRY: Self Employed
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Merrillville
13d. STREET AND NUMBER: 417 W 75th Place
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX 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): 12; College (1-4 or 5 +): 3

PARENTS

18. FATHER'S NAME (First, Middle, Last): Andrew Murray
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Norman

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Shirley Murray
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 417 W.75th Place Merrillville,In.46410
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) ________
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 5, 1992 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville,Indiana
22a. EMBALMER'S NAME: Robert A. Craigin Jr.
22b. EMBALMER'S LICENSE NO.: FDO 8700735
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Alexis Thomas
24b. LICENSE NUMBER (of Licensee): FDO 8600505
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762 7905 Broadway,Merrillville,In.46410

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. metastatic Sertoli-Leydig tumor	13 months
	DUE TO (OR AS A CONSEQUENCE OF): b.	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	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

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): 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: Mary Kline MD
29c. MEDICAL LICENSE NO.: 61034294
29d. DATE SIGNED (Month, Day, Year): February 7, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Mary KlineM.D. 1190 N. State Rd. 49, Porter,Indiana 46469

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S Williams, M.D.
32. DATE FILED (Month, Day, Year): Feb. 13, 1992

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 If yes, specify driver, passenger, pedestrian, etc.

FILED SEP 17 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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CHICAGO TITLE INSURANCE COMPANY

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