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COMMUNITY TITLE COMPANY
FILE NO 142262

PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Hazel E. Tucker
2. SEX: female
3a. TIME OF DEATH: 10:20a M
3b. DATE OF DEATH (Month, Day, Yr.): December 1 1991
4. SOCIAL SECURITY NUMBER: 314-05-6151
5a. AGE—Last Birthday (Years): 94
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Mar 21 1991
7. BIRTHPLACE (City and State or Foreign Country): South Bend IN
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 ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Fountainview Place
9c. CITY, TOWN, OR LOCATION OF DEATH: Portage
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Sales
12b. KIND OF BUSINESS/INDUSTRY: Goldblats
13a. RESIDENCE—STATE: IN
13b. COUNTY: Porter
13c. CITY, TOWN, OR LOCATION: Portage
13d. STREET AND NUMBER: 3175 Lancer
13e. ZIP CODE: 46368
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Lyman Reading
19. MOTHER'S NAME (First, Middle, Maiden Surname): Marietta Inman

INFORMANT

20a. INFORMANT'S NAME (Type/Print): William Tucker
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2865 Irvine St. Portage, Indiana
20c. Relationship: grandson

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Dec 4 1991 Chapel Lawn
21c. LOCATION—City or Town, State: Shererville IN
22a. EMBALMER'S NAME: M. Chad Olmsted
22b. EMBALMER'S LICENSE NO.: Fd0880056
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Vernon R. Engel
24b. LICENSE NUMBER (of Licensee): 1002964
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Engel Funeral Home 2700 Willowcreek Rd. Portage IN 46368 3007893

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. acute cerebral anoxia
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Heart Disease
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

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or 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:
29c. MEDICAL LICENSE NO.: 01033961
29d. DATE SIGNED (Month, Day, Year): 12/4/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Leonard Ostrowski, MD 3125 Willowcreek Rd. Portage IN 46368

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Leonard Ostrowski MD
32. DATE FILED (Month, Day, Year): DECEMBER 4, 1991

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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

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