

TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

Below for State Office Use

THIS IS A TRUE AND  
 COMPLETE COPY OF THE CERTIFICATE OF DEATH  
 ON FILE WITH THE LAKE COUNTY HEALTH DEPT.  
 APR 23 1982  
 FILED  
 MAR 22 1982  
 Disposition Permit Issued  
 Provisional Certificate  
 Yes  No

APR 23 1981 5346

EMBALMER: *James S. Sheets*  
 WILLIAM A. SHEETS  
 LAKE COUNTY, INDIANA

FUNERAL HOME  
427

FUNERAL DIRECTOR'S  
AGENCY NO. 2258

FUNERAL DIRECTOR'S  
SIGNATURE: *W. D. Sheets*

652807

Local No. 613-81

TYPE OR PRINT  
IN PERMANENT  
INK FOR  
INSTRUCTIONS  
SEE  
HANDBOOK

DECEASED

USUAL RESIDENCE  
WHERE DECEASED  
LIVED. IF DEATH  
OCCURRED IN  
INSTITUTION, GIVE  
RESIDENCE BEFORE  
ADMISSION

LAKE COUNTY HEALTH DEPT.

DISPOSITION

M.D.  
OR  
D.O.

CONDITIONS  
IF ANY  
WHICH GAVE  
RISE TO  
IMMEDIATE  
CAUSE  
STATING THE  
UNDERLYING  
CAUSE LAST

CAUSE

INDIANA STATE BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

State No. \_\_\_\_\_

1 DECEASED—NAME FIRST MIDDLE LAST Willard C. Eades		2 SEX Male	3 DATE OF DEATH (MONTH, DAY, YEAR) 4-18-1981
4 RACE White	5a AGE—Last Birthday (Yrs) 73	5b UNDER 1 YEAR MOS DAYS	5c UNDER 1 DAY HOURS MINS
6 DATE OF BIRTH (Mo., Day, Yr.) 3-27-1908		7a COUNTY OF DEATH Lake	
7b CITY, TOWN OR LOCATION OF DEATH Crown Point		7c HOSPITAL OR OTHER INSTITUTION—Name of inst. (number, gross street and number) St Anthony's Hospital	
8 STATE OF BIRTH (If not in U.S.A. name country) Illinois		9 CITIZEN OF WHAT COUNTRY USA	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
11 SURVIVING SPOUSE (If male give maiden name) Helen Besaw		12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) No	
13 SOCIAL SECURITY NUMBER 312-09-9106		14a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipefitter	14b KIND OF BUSINESS OR INDUSTRY Standard Oil
15a RESIDENCE—STATE Indiana	15b COUNTY Lake	15c CITY, TOWN OR LOCATION Shelby	
15d STREET AND NUMBER 23219 Buchanan Street		15e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15f INSIDE CITY LIMITS (Specify block) Yes
16 IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
17 FATHER—NAME FIRST MIDDLE LAST Charles M. Eades		18 MOTHER—MAIDEN NAME FIRST MIDDLE LAST Daisy Mae Highfill	
19 DECEASED—NAME (Type as printed) Helen Eades		20 MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 23219 Buchanan Street Shelby, Indiana 46327	
21 BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		22 CEMETERY OR CREMATORY—FUNERAL HOME LOCATION CITY OR TOWN Lowell Memorial Park Lowell, Indiana	
23 DATE (MONTH, DAY, YEAR) 4-21-1981		24 FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Sheets Funeral Home 604 E. Commercial Ave. Lowell, In. 46356	
25 To the best of my knowledge, death occurred at the time, date and place and due to the causes stated <i>Sampanta Boonjarern M.D.</i>		26 DATE SIGNED (Mo., Day, Yr.)	27 HOUR OF DEATH 7:22 p.m.
28 NAME OF ATTENDING PHYSICIAN (Type as Printed) Sampanta Boonjarern M.D.		29 MAILING ADDRESS—PHYSICIAN 2068 Lucas Parkway Lowell, Indiana 46356	
30 HEALTH OFFICER—SIGNATURE <i>Peen Jacy M.D.</i>		31 DATE RECEIVED BY LOCAL HEALTH OFFICER 4-23-81	
32 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PLEASE FOR (a), (b), AND (c)) PART I (a) Cardiopulmonary failure DUE TO OR AS A CONSEQUENT OF: Coronary artery disease, status post coronary artery bypass surgery; (b) chronic obstructive lung disease DUE TO OR AS A CONSEQUENT OF: Hepatic failure, renal failure, gangrene of small bowel, obstructive carcinoma of the colon		33 Interval between onset and death days Interval between onset and death months Interval between onset and death	
34 OTHER SIGNIFICANT CONDITIONS (Circumstances contributing to death but not related to cause given in PART I (a))		35 AUTOPSY (Specify Yes or No) No	