

824296

INDIANA STATE BOARD OF HEALTH
CORONER'S CERTIFICATE OF DEATH

Ullrich Eaton
1525 E. 35th Pl.
Gary 46409
State No. 0

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

Below for State Office Use

FILED

OCT 15 1985

HAMMOND HEALTH COMMISSIONER

4237

47-98-14

Charles Wells

EMBALMER'S NAME

FUNERAL HOME

FUNERAL DIRECTOR'S

FUNERAL DIRECTOR'S

Auditor Lake County

LICENSE No. 2497

SIGNATURE

Local No. 22

TYPE OR PRINT
IN
PERMANENT
INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

DECEASED

IF DEATH
OCCURRED IN
INSTITUTION
SEE HANDBOOK
REGARDING
COMPLETION OF
RESIDENCE ITEMS.

PARENTS

DISPOSITION

CERTIFIER

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

CAUSE

DECEASED—NAME 1. Virginia D. Eaton			SEX 2. Female	DATE OF DEATH (MONTH, DAY, YEAR) 3. Jan. 5, 1979
RACE—(a) White, Black, American Indian, etc. (Specify) 4. White	AGE—Last Birthday (Yrs.) 5a. 47	UNDER 1 YEAR 5b. 47	UNDER 1 DAY 5c. 47	DATE OF BIRTH (Mo., Day, Yr.) 6. Mar. 1, 1931
CITY, TOWN OR LOCATION OF DEATH 7b. Hammond		HOSPITAL OR OTHER INSTITUTION—Name (if not in other, give street and number) 7c. Kennedy Park Apt 26 Bldg 24		IF HOSP. OR INST. Indicate DOA, OP/Emar. Rn., Impover. (Specify) 7d. N/A
STATE OF BIRTH (If not in U.S. A. name country) 8. Tenn.	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. divorced	SURVIVING SPOUSE (If wife, give maiden name) 11. N/A	WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) 12. no
SOCIAL SECURITY NUMBER 13. 383-28-6422	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a. Receptionist		KIND OF BUSINESS OR INDUSTRY 14b. Apartment Complex	
RESIDENCE—STATE 15a. Indiana	COUNTY 15b. Lake	CITY, TOWN OR LOCATION 15c. Hammond		RESIDENCE ON A FARM? 15d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
STREET AND NUMBER 15d. Kennedy Park Apt. 26 Bldg. 24		INSIDE CITY LIMITS (SPECIFY YES OR NO) 15f. yes		IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
FATHER—NAME 16. Thomas D. Hancock		MOTHER—MAIDEN NAME 17. Lillie Mitchell		
INFORMANT—NAME (Type or print) 18a. Philip Eaton		MAILING ADDRESS 18b. 2151 Sherwood Lake Dr., Apt. 2C, Schererville, Ind. 46375		
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b. Chapel Lawn		LOCATION 19c. Schererville, Indiana
DATE (MONTH, DAY, YEAR) 20a. January 9, 1979		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 20b. Virgil Huber Funeral Home, 7051 Kennedy Ave., Hammond, Ind. 46323		
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) stated.		DATE SIGNED (Mo., Day, Yr.) 21b. 2/7/79	HOUR OF DEATH 21c. 2:06 PM	
21a. Signature <i>[Signature]</i>		PRONOUNCED DEAD (Mo., Day, Yr.) 21d. ON 1/5/79	PRONOUNCED DEAD (Hour) 21e. AT 2:06 PM	
NAME AND ADDRESS OF CERTIFIER (Type or Print) 21f. ALBERT T. WILLARDO, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307		DATE RECEIVED BY LOCAL HEALTH OFFICER 22b. 2-7-79		
HEALTH OF DECEASED (Specify) 22a. <i>[Signature]</i>		22c. 2-7-79		
IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) PART I (a) Vascular collapse due to		Interval between onset and death Undetermined		
(b) overdose of combination of		Interval between onset and death		
(c) drugs.		Interval between onset and death		
OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a) PART II		AUTOPSY (Specify Yes or No) 24. Yes		
ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 25a. Accidental	DATE OF INJURY (Mo., Day, Yr.) 25b. 1/5/79	HOUR OF INJURY 25c. 1/5/79	DESCRIBE HOW INJURY OCCURRED 25d. Combination of drugs & alcohol	
INJURY AT WORK (Specify Yes or No) 25e. No	PLACE OF INJURY—As home, farm, street, factory, office building, etc. (Specify) 25f. Home	LOCATION 2838 178th Pl. Kennedy Ave., Hammond, Ind.		

THIS CERTIFIES THE ABOVE IS A TRUE AND
COMPLETE COPY OF THE CERTIFICATE OF DEATH
ON FILE WITH THE HAMMOND HEALTH DEPT.

[Signature]
1985

[Signature]
Date Issued

[Signature]
#

Disposition Permit
IssuedProvisional
Certificate
 Yes No

RECORDED
OCT 15 1985
FILED
STATE OF INDIANA
HAMMOND

[Signature]