

TYPE OR PRINT
PLAINLY, WITH
UNFADING INK

THIS IS A
PERMANENT
RECORD

Below for State Office Use

Com 137077-87
146

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

Sec Title Ins
Hd

State No. _____

943181
Local No. _____

90-39-40-28

FUNERAL HOME
No. 729

FUNERAL DIRECTOR'S
LICENSE No. 965

EMBALMER'S NAME
Thos. Owens

EMBALMER'S NAME
Thos. Owens

FUNERAL DIRECTOR'S
SIGNATURE
W. D. ...

HAMMOND HEALTH COMMISSIONER

Date Issued

THIS CERTIFIES THE ABOVE IS A TRUE AND
COMPLETE COPY OF THE CERTIFICATE OF DEATH
ON FILE WITH THE HAMMOND HEALTH DEPT.
FEB 23 1987
Franklin G. Remuda M.D.

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

PARENTS

DISPOSITION

M.D.
OR
D.O.

CONDITIONS
WHICH LEAD
TO
IMMEDIATE
CAUSE
STATING THE
UNDERLYING
CAUSE LAST

CAUSE

DECEASED NAME FIRST MIDDLE LAST Elizabeth Vater			SEX Female	DATE OF DEATH (MONTH DAY YEAR) 2-18-87	
RACE - (e.g. White, Black, American Indian, etc.) White	AGE - Last Birthday (YRS) 74	UNDER 1 YEAR MOS DAYS	UNDER 1 DAY HOURS MINS	DATE OF BIRTH (MO DAY YR) 11-10-13	COUNTY OF DEATH Lake
CITY, TOWN OR LOCATION OF DEATH Hammond,		HOSPITAL OR OTHER INSTITUTION - Name and number, give street and number. St. Margaret Hosp.		IF HOSP OR INST indicate DOA OF Emer. Rm. Inpatient/Specier	
STATE OF BIRTH (if not in U.S. name country) In.	CITIZEN OF WHAT COUNTRY U.S.A.	MARRIED NEVER MARRIED WIDOWED DIVORCED never	SURVIVING SPOUSE (if wife give the last name)		WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify type of War) no
SOCIAL SECURITY NUMBER 313-01-4206		USUAL OCCUPATION (Give kind of work done during most of past 12 months) oil worker		KIND OF BUSINESS OR INDUSTRY A.M.O.CO. Oil	
RESIDENCE - STATE In.	COUNTY U.S.A.	CITY, TOWN OR LOCATION Whiting		14b	
STREET AND NUMBER 1820 Sheridan			IS RESIDENCE ON A FARM? 15e YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INSURANCE LIMITS (Specify type of insurance) 8 53 AM '87
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 FIRST MIDDLE LAST Charles Vater		MOTHER - MAIDEN NAME FIRST MIDDLE Mollie W...		STATE OF BIRTH (if not in U.S. name country) In.	
INFORMANT - NAME (Type or print) RELATIONSHIP Ruth Vater S-in-law		MAILING ADDRESS STREET AND NO CITY OR TOWN STATE 1707 Caroline Av. Whiting 46394		STATE OF BIRTH (if not in U.S. name country) In.	
BURIAL, CREMATION, REMOVAL OTHER Burial.		CEMETERY OR CREMATORY - FUNERAL HOME Concordia Cem.		LOCATION CITY OR TOWN STATE Hammond In.	
DATE (MONTH DAY YEAR) 2-20-1987		FUNERAL HOME - NAME AND ADDRESS Owens F.H. 816-119th St. Whiting, In.		DATE SIGNED (MO DAY YR) 2/17/87	
SIGNATURE James B. Walsh		DATE SIGNED (MO DAY YR) 2/17/87		HOUR OF DEATH 11:45 a.m.	
NAME OF ATTENDING PHYSICIAN (Type or print) J.B. Walsh, M. D.		MAILING ADDRESS - PHYSICIAN 5500 Hohman Avenue, Hammond, Indiana 46320		SIGNED BY LOCAL HEALTH OFFICER FEB 23 1987	
HEALTH OFFICER'S SIGNATURE <i>Franklin G. Remuda M.D.</i>		SIGNED BY LOCAL HEALTH OFFICER FEB 23 1987		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months	
IMMEDIATE CAUSE Cor Pulmonale		INTERVENING CAUSE (Specify for 1, 2, and 3)		INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART I (a) DUE TO OR AS A CONSEQUENCE OF Swiss Emphysema		PART I (b) DUE TO OR AS A CONSEQUENCE OF		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS (Specify for 1, 2, and 3) Osteoarthritis (2) Hypertension		PART II		AUTOPSY (Specify Yes or No) NO	

TICOR TITLE INSURANCE
Crown Point, Ind. 46032
STATE OF INDIANA
L.C. RECORDER
SEP 29
Central Ph Add R33 BL 8
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