094730

Local No. 191-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Mary E. Kennedy
2 SEX: Female
3a TIME OF DEATH: 12:22P M
3b DATE OF DEATH (Month Day Yr): February 22, 1990
4 SOCIAL SECURITY NUMBER: 307-20-3306
5a AGE—Last Birthday (Years): 64
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): MAY 1, 1925
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Ill.
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Anthony's Medical Center
9c CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): William L. Kennedy
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Housewife
12b KIND OF BUSINESS/INDUSTRY: At Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Crown Point
13d STREET AND NUMBER: 322 Ellendale Parkway
13e ZIP CODE: 46307
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): ; College (1-4 or 5+): 4

PARENTS

18 FATHER'S NAME (First Middle Last): William F. Carroll
19 MOTHER'S NAME (First Middle Maiden Surname): Lorraine Lenz

INFORMANT

20a INFORMANT'S NAME (Type/Print): William L. Kennedy
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 322 Ellendale Pkwy., Crown Point, In 46307
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): FEB 26, 1990 Maplewood Memorial Cemetery
21c LOCATION—City or Town State: Crown Point, Indiana
22a EMBALMER'S NAME: Marty Andersen
22b EMBALMER'S LICENSE NO: FD01005205
23 WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD01000328
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. - FD83001253, 109 N East St, Crown Point, IN46307

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

IMMEDIATE CAUSE (Final disease or condition resulting in death) a: Cerebral [illegible] — Approximate Interval Between Onset and Death: several days
DUE TO (OR AS A CONSEQUENCE OF) b: Cerebral [illegible] — unknown
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 contributing to death but not resulting in the underlying cause given in Part I: 1) Metastatic [illegible] 2 Severe [illegible] ischemic cardiomyopathy

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a CERTIFIER (Check 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: [signature] MD
29c MEDICAL LICENSE NO: 0-18811
29d DATE SIGNED (Month Day Year): 2-26-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ernest C. Mirich MD, 9001 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): FEB 26, 90

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? (Yes or no) If yes specify driver passenger pedestrian etc

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

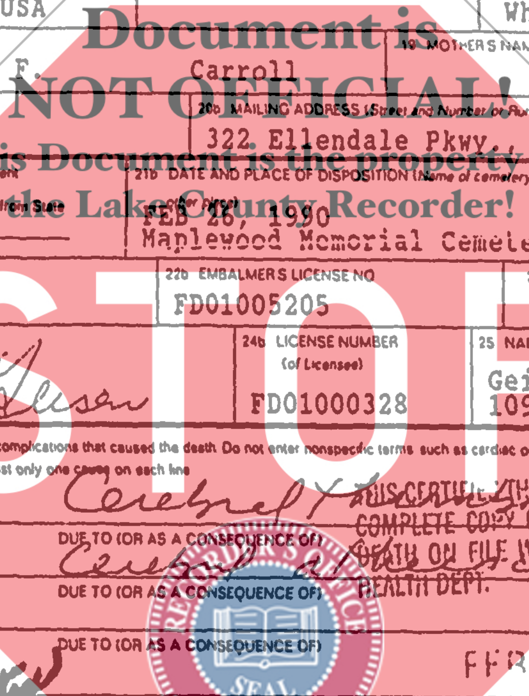
FEB 26 1990

FILED APR 10 1990

#9-25-6, 7, 8 Ellendale 2nd City Park add. Lts 6, 7, 8

000262

SBH06-004 State Form 10110 (R2/3-89) CEA CERT PO 1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