[redacted]

91009189 INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 387-91

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	LUCILLE ELIZABETH BIRR
2. SEX	FEMALE
3a. TIME OF DEATH	12:00A.M.
3b. DATE OF DEATH (Month, Day, Yr)	FEBRUARY 17, 1991
4. SOCIAL SECURITY NUMBER	360-01-2220
5a. AGE—Last Birthday (Years)	70
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	OCTOBER 9, 1920
7. BIRTHPLACE (City and State or Foreign Country)	TOPEKA, KANSAS
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)	THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	MUNSTER
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	MELVIN BIRR
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	COOK
12b. KIND OF BUSINESS/INDUSTRY	RESTAURANT
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HIGHLAND
13d. STREET AND NUMBER	3143 GLENWOOD ST.
13e. ZIP CODE	46322
13f. INSIDE CITY LIMITS	☐ No XX Yes
13g. ON A FARM?	XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	X No ☐ Yes
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+)	10

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	ADAM DOMME
19. MOTHER'S NAME (First, Middle, Maiden Surname)	CATHERINE MELCHIOR

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MELVIN BIRR
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3143 GLENWOOD ST. HIGHLAND, INDIANA 46322
20c. Relationship	HUSBAND

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	FEBRUARY 19, 1991 MEMORY LANE MEMORIAL PARK
21c. LOCATION—City or Town, State	SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME	LAWRENCE MILLER
22b. EMBALMER'S LICENSE NO.	FD01006015
23. WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Lawrence Miller
24b. LICENSE NUMBER (of Licensee)	FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FAGEN-MILLER FUNERAL GARDENS, INC. 2828 HIGHWAY AVE. HIGHLAND, INDIANA FH83003035

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 or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cardio pulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

b. History of Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Hypertension and

DUE TO (OR AS A CONSEQUENCE OF):

d. Insulin dependent diabetes mellitus

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Field	Entry
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	NO
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 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	36983
29d. DATE SIGNED (Month, Day, Year)	FEBRUARY 18 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	IRIS LEGASRE M.D. 1801 WEST GLEN PARK AVE. GRIFFITH, INDIANA 46319

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams M.D.
32. DATE FILED (Month, Day, Year)	February 20 1991

CORONER USE ONLY

Field	Entry
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.	

01836

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Homestead Gardens L. 2 #27-264-2 BCS

FILED FEB 21 1991 AUDITOR LAKE COUNTY

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

FEB 21 1991