6640 Madison
Hammond, IN 46324

91015007

INDIANA STATE BOARD OF HEALTH

Local No. 150-91

CERTIFICATE OF DEATH

FILED

State No APR. 2 1991

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Geraldine Gentry
2. SEX: female
3a. TIME OF DEATH: 2:16 AM
3b. DATE OF DEATH (Month, Day, Yr): January 24, 1991
4. SOCIAL SECURITY NUMBER: 316-24-6850
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 23, 1926
7. BIRTHPLACE (City and State or Foreign Country): Metropolis, Ill
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): Our Lady Of Mercy
9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Stay Home
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN, OR LOCATION: Lynwood
13d. STREET AND NUMBER: 344 Patti Lane
13e. ZIP CODE: 60411
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
16a. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Francis Shook
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mabey Johnson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lynne Moulesong
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 939 Statford Lane Dyer, Indiana 46311
20c. Relationship: daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Elmwood Cemetery January 24, 1991
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: R. A. S.
24b. LICENSE NUMBER (of Licensee): FD01018769
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: C.J. Huber Funeral Home 722 165th Hammond, Indiana 46324 FDH3002851

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. Respiratory Failure — Approximate Interval Between Onset and Death: 2 weeks
DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell Carcinoma Lung — 6 months
DUE TO (OR AS A CONSEQUENCE OF): c. ~~Diabetes Mellitus~~
DUE TO (OR AS A CONSEQUENCE OF): d.

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

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

PART II. Other significant conditions • Conditions contributing to death but not previously stated in Part I: DIABETES Mellitus

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): N/A

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Steven A. Corse MD
29c. MEDICAL LICENSE NO.: 02000686
29d. DATE SIGNED (Month, Day, Year): January 22, 1991

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Steven A. Corse, D.O. 3100 45th St. Highland, IN 46322
31. HEALTH OFFICER'S SIGNATURE: Robert Gaskie MD
32. DATE FILED (Month, Day, Year): Jan 23 19 C

CORONER USE ONLY

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): 600
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

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Key # 35-6-11 Madison Terrace 4.22 Hammond
TAXES: 6640 Madison Ave Hammond IN 46324 BL 6