Mary Ann Cox 3145

PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE

91015491

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1 DECEASED—NAME (First Middle Last)	VERA L. PERDUE
2 SEX	FEMALE
3a TIME OF DEATH	1:10 P.M
3b DATE OF DEATH (Month Day Yr)	MARCH 17, 1991
4 SOCIAL SECURITY NUMBER	305-28-6894
5a AGE—Last Birthday (Years)	62
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	FEBRUARY 25, 1929
7 BIRTHPLACE (City and State or Foreign Country)	IDAVILLE, INDIANA
8a WAS DECEDENT A U.S. VETERAN?	NO
8b YEAR LAST SERVED IN US ARMED FORCES?	NONE
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)	PAVILION HEALTH CARE CENTER
9c CITY, TOWN, OR LOCATION OF DEATH	VALPARAISO
9d COUNTY OF DEATH	PORTER
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name)	WILLIAM P. PERDUE
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	AT HOME
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN, OR LOCATION	GARY
13d STREET AND NUMBER	4200 CAROLINA
13e ZIP CODE	46409
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ 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+)	12

PARENTS

Field	Value
18 FATHER'S NAME (First, Middle, Last)	CARL CULLUMS
19 MOTHER'S NAME (First, Middle, Maiden Surname)	LUCILLE HASTINGS

INFORMANT

Field	Value
20a INFORMANT'S NAME (Type/Print)	WILLIAM P. PERDUE
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4200 CAROLINA, GARY, INDIANA 46409
20c Relationship	HUSBAND

DISPOSITION

Field	Value
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	MARCH 20, 1991 RIDGELAWN CEMETERY
21c LOCATION—City or Town, State	GARY, INDIANA
22a EMBALMER'S NAME	GORDON L. JONES
22b EMBALMER'S LICENSE NO	1010711
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	James F. Burns
24b LICENSE NUMBER (of Licensee)	1009461
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BURNS FUNERAL HOME FDH#83002380 701 E. 7th STREET, HOBART, IN. 46342

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. pneumonia
DUE TO (OR AS A CONSEQUENCE OF)
b. COPD
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. Conditions contributing to death but not previously stated in Part I: Obstructive Biliary disease 3° to stone; Urinary tract infection; CVA - senility

Field	Value
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	Value
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	01024990
29d DATE SIGNED (Month, Day, Year)	March 19, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	JOHN L. SWARNER, M. D., 1101 E. GLENDALE BLVD., VALPARAISO, INDIANA 46383 (464-9054)

HEALTH OFFICER

Field	Value
31 HEALTH OFFICER'S SIGNATURE	[signature], MD
32 DATE FILED (Month, Day, Year)	March 21, 1991

CORONER USE ONLY

Field	Value
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.	

600

Woodlawn Park Add L.1 to 4, Bl.7
Key# 47-330-1,3,+4 unit# 25

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

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FILED APR 3 1991 Anna M. Anton AUDITOR LAKE COUNTY

STATE OF INDIANA, LAKE COUNTY, RECORDED