TAXES: 7709 W. 89th Pl., Crown Point, In. 46307

INDIANA STATE BOARD OF HEALTH

Local No. ..... 91020825 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
Vesta	Wools	Female	5:39 PM	January 3, 1991

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
312-16-5359	70			Sept 12, 1920	Linton, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	No	HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Our Lady of Mercy Hospital ER	Dyer	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Ocie Wools	Homemaker	Own Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Crown Point	7709 West 89th Place

13e. ZIP CODE	13f. INSIDE CITY LIMITS?	13g. ON A FARM?	14. CITIZEN OF — WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
46307	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	8

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Goodman	Anna Oddessa

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Ocie Wools	7709 W 89th Pl., Crown Point, IN 46307	Husband

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	January 7, 1991 Chapel Lawn Memorial Gardens	Schererville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Raymond White	FDO 8700086	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01014511	Kuiper Funeral Home FDH 300-7500 9039 Kleinman Rd., Highland, IN 46322

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. Hyperglycemia	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Blood glucose 938 mg/dl	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

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

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Daniel D. Thomas M.D.	16120	February 20, 1991

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29) (Type/Print)
Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, IN 46307

31. HEALTH OFFICER'S SIGNATURE
Alexander S. Williams, M.D.

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

32. DATE FILED (Month, Day, Year) July 21, 1991

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				FEB 21 1991

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)
	Charles Johnson

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
January 3, 1991	LAKE COUNTY HEALTH COMMISSIONER 00054

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