91023206

INDIANA STATE BOARD OF HEALTH

Local No. ...S.C.-89.....

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First / Middle / Last)	2 SEX	3 DATE OF DEATH (Mo. Day. Yr.)
Paulette / Mathena	F	February 19,1989

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 (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
304-42-5884	48			Aug.16,1940	East Chicago, In

8 YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
N/A	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital Southlake Campus	Merrillville	Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (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	Jack Mathena	Home Maker	Own Home

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hobart	910 W. 7th Pl.

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
Yes	No	46342		White	12	

FILED

PARENTS

17 FATHER'S NAME (First, Middle, Surname)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
Paul Pope	Violette Stross

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
Jack Mathena	910 W. 7th Pl. Hobart, Indiana	Husband

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	February 22, 1989 Oakland Memory Lane	Dolton, Illinois

21a SIGNATURE OF FUNERAL DIRECTOR — 21b LICENSE NUMBER (of Licensee): FDO 1014511 — 22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home-9039 Kleinman Rd. Highland, Indiana FDH 300-7500

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <

23b LICENSE NUMBER

23c DATE SIGNED (Month, Day, Year)

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month, Day, Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
6:15 P M	February 19, 1989	NO

CAUSE OF DEATH

SEE INSTRUCTIONS

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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): CARCINOMA OF BREAST WITH BRAIN & LIVER METASTASES

DUE TO (OR AS A CONSEQUENCE OF):

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Sequentially list conditions, if any, leading to the immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.

Approximate Interval Between Onset and Death: 2 yr.

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

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

SEE INSTRUCTIONS

29a CERTIFIER (Check only one)

CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

LAKE COUNTY HEALTH COMMISSIONER

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
	030107	2/20/89

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DR. BARAI 521 E. 81TH MERRILLVILLE, IN

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month, Day, Year): Feb. 21, 89

CORONER OR MEDICAL EXAMINER 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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				00931

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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PDI