PORTER COUNTY BOARD OF HEALTH
CERTIFICATE OF DEATH

91023698

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TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME	FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Mo., Day, Yr.)
	MAXINE	L.	BENEDICT	Female	November 14, 1988

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)
309-30-6947	60			Jun.11,1928	Gary, Indiana

8. YEAR LAST SERVED IN U.S. ARMED FORCES? No

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)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Porter Memorial Hospital	Valparaiso	Porter

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	Richard L. Benedict	Homemaker	At Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Porter	Valparaiso	76 East U.S. Hwy. 6 Lot 118

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.) 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	46383	☒ No ☐ Yes	White	12	

PARENTS

17. FATHER'S NAME (First, Middle, Last) George Holtzman

18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeannette Long

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
Richard L. Benedict	76 E. U.S. Hwy. 6 Valparaiso, In 46383	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)	November 18, 1988 Calumet Park Cemetery	Merrillville, Indiana

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Ronald E. Mesarch	FDE1005912	Geisen Funeral Home Inc. FDH3007762 7905 Broadway Merrillville, In 46410

PRONOUNCING PHYSICIAN ONLY

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 24990	23c. DATE SIGNED (Month, Day, Year) November 14, 1988

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

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
2:46 P M	November 14 1988	No

SEE INSTRUCTIONS

CAUSE OF DEATH

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)
a. Funeral Home
DUE TO (OR AS A CONSEQUENCE OF)
b. Pulmonary Edema Chronic GI Bleed
DUE TO (OR AS A CONSEQUENCE OF)
c. Chronic Anemia
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) 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.
Coronary Artery Disease, Coronary Bypass, Diabetes Mellitus, Peripheral Vascular Disease

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	MAY 17 1991

FILED

SEE INSTRUCTIONS

CERTIFIER

29a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 27) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ 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.

Aaron N. Antoine
AUDITOR LAKE COUNTY

☐ 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)
	24990	November 14, 1988

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) John L. Swarner Jr. 1101 Glendale Blvd. Valparaiso, In 46383

31. HEALTH OFFICER'S SIGNATURE John L. Swarner M.D.

32. DATE FILED (Month, Day, Year) November 17 1988

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				

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 (R/10-87) DEATH/PO 1

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