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91024382

Local No. 0963-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Jeanne G Edington
2. SEX: Female
3a. TIME OF DEATH: 1:40p M
3b. DATE OF DEATH (Month, Day, Yr): May 4, 1991
4. SOCIAL SECURITY NUMBER: 328-14-3507
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): FEBRUARY 25, 1915
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, IND.
8a. WAS DECEDENT A US VETERAN?: NO
8b. YEAR LAST SERVED IN US ARMED FORCES?: ——
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): MUNSTER MED-INN
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): LESTER EDINGTON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RETIRED PRESSER
12b. KIND OF BUSINESS/INDUSTRY: STRATO JACKET CO
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 6315 RHODE ISLAND AVE
13e. ZIP CODE: 46323
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
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): PIOTR FYDA
19. MOTHER'S NAME (First, Middle, Maiden Surname): KERY N/A

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LESTER EDINGTON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6315 RHODE ISLAND, HAMMOND, IND. 46323
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 7, 1991 OAKLAND MEMORY LANES
21c. LOCATION—City or Town, State: DOLTON, ILLINOIS
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO.:
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS-KISH FUNERAL HOME 5840 HOHMAN AVE HAMMOND, IND.

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.
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: Advanced Chronic Obstructive Pulmonary Disease; Hypertension

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

FILED MAY 21 1991

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: [signature] M D
29c. MEDICAL LICENSE NO.: 01024492
29d. DATE SIGNED (Month, Day, Year): 5/6/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. J. Perez 7905 Calumet Ave, Munster IN 46321 M.D

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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): MAY 08 1991 / MAY 8, 91

LAKE COUNTY HEALTH COMMISSIONER

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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.

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

Taxes: 4242 N. Harlem c/o Talman Home Mtg Chicago, IL 60634; Cline-way add N 15 ft L21 & 2 L22 Bl 2 530 ft; Key# 32-150-22