

5 CC'S 92002191

INDIANA STATE BOARD OF HEALTH

Local No. 3263-91

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) Neal H. Shell		2 SEX Male	3a TIME OF DEATH 8:20 P.M.	3b DATE OF DEATH (Month, Day, Year) December 22, 1991
4 SOCIAL SECURITY NUMBER 311-26-4457	5a AGE—Last Birthday (Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) August 9, 1928
7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	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 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		

DECEDENT

9b FACILITY NAME (If not institution give street and number) Methodist Hospital Southlake Campus	9c CITY, TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake
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10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Gloria Underwood	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pipefitter	12b KIND OF BUSINESS/INDUSTRY Steel Industry
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13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Crown Point	13d STREET AND NUMBER 9440 Randolph Street
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13a ZIP CODE 46307	13i INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 10-12: 12 College (1-4 or 5+)
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PARENTS

18 FATHER'S NAME (First, Middle, Last) Howard Shell	19 MOTHER'S NAME (First, Middle, Maiden Surname) Adeline Miller
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INFORMANT

20a INFORMANT'S NAME (Type/Print) Gloria Shell	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9440 Randolph St., Crown Point, In. 46307	20c Relationship Wife
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DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 27, 1991 Calumet Park Cemetery	21c LOCATION—City or Town, State Merrillville, Indiana
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22a EMBALMER'S NAME Alexis Thanos	22b EMBALMER'S LICENSE NO. FD08600505	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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24a SIGNATURE OF FUNERAL DIRECTOR <i>Markert J. Shuman</i>	24b LICENSE NUMBER (of Licensee) FD01041740	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410
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CAUSE OF DEATH

26: PART I Enter the disease, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)  
Metastatic cancer of gastroesophageal junction

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:  
a. DUE TO (OR AS A CONSEQUENCE OF)  
b. DUE TO (OR AS A CONSEQUENCE OF)  
c. DUE TO (OR AS A CONSEQUENCE OF)

Approximate Interval Between Onset and Death  
12-15 hrs

PART II Other conditions contributing to death but not previously stated in Part I. Conditions contributing to death but not previously stated in Part I. DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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) No
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CERTIFIER

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Alexander S. Williams, MD</i>	29c MEDICAL LICENSE NO. 01031667	29d DATE SIGNED (Month, Day, Year) 12/30/91
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Pimpa J. Tara, M.D., 8127 Merrillville Road, Merrillville, Indiana 46410	31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>	32. DATE FILED (Month, Day, Year) December 30, 1991
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CORONER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY FILED	34c INJURY AT WORK? (Yes or no) FILED	34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) JAN 13 1992		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. <i>Alexis N. Anton</i> AUDITOR LAKE COUNTY	006775
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75. J.A.M.C. 10-7-91 15-389-7 Meadow Valley found adds to Lake County

