Local No. 08641-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

92002303

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Virginia J. Dyer

2 SEX: Female

3a TIME OF DEATH: 7:45 P.M.

3b DATE OF DEATH (Month Day Yr): April 20, 1991

4 SOCIAL SECURITY NUMBER: 297-01-8316

5a AGE—Last Birthday (Years): 75

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo Day Yr): Jun. 7, 1915

7 BIRTHPLACE (City and State or Foreign Country): Youngstown, Ohio

8a WAS DECEDENT A U.S. VETERAN? NO

8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A

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): 1416 N. Griffith, Blvd

9c CITY, TOWN OR LOCATION OF DEATH: Griffith

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): William Dyer

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker

12b KIND OF BUSINESS/INDUSTRY: Own Home

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Griffith

13d STREET AND NUMBER: 1416 N. Griffith, Blvd

13e ZIP CODE: 46319

13f INSIDE CITY LIMITS: ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Paul Renz

19 MOTHER'S NAME (First, Middle, Maiden Surname): Martha Kroll

INFORMANT

20a INFORMANT'S NAME (Type/Print): William Dyer

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 N. Griffith Blvd Griffith, Indiana

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 4-23-91 Chapel Lawn Cemetery

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: Ronald A. Reed

22b EMBALMER'S LICENSE NO: FDO 1001081

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FDO 1014511

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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.

FILED JAN 10 1992

[signature] AUDITOR LAKE COUNTY

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Myocardial infarction	Seconds
b. DUE TO (OR AS A CONSEQUENCE OF)	Coronary Artery disease	Years
c. DUE TO (OR AS A CONSEQUENCE OF)	Atherosclerosis	
DUE TO (OR AS A CONSEQUENCE OF)		

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: Cerebral Vascular Accident

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)

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: H Alan Jones DO

29c MEDICAL LICENSE NO: 640

29d DATE SIGNED (Month Day Year): 4-22-91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 9128 Columbia Ave Munster IND 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD

32 DATE FILED (Month Day Year): April 22 1991

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: Frances J. O'Rourke 5231 Hohman Ste 501 Ham 46320

I HEREBY CERTIFY THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF ... COUNTY ... COMMISSIONER