INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 936 — 92002979

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Date Issued NOV 30 1991 — Franklin D. Jemudes M.D. — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
LILLIAN	McCAIN	Female	3:30 AM	November 14, 1991

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 (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
304-64-8913	76			August 7, 1915	East Chicago, Indiana

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	None	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
7113 Howard Ave.	Hammond	Lake

10 MARITAL STATUS (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 W. McCain	Housewife	Homemaker

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	7113 Howard Ave.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46324	XX No ☐ Yes	XX No ☐ Yes	U.S.A.	☐ No ☐ Yes	White	12 years	--

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Edward Schmitt	Lillian Mitchell

INFORMANT

20a INFORMANT'S NAME (Type Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Richard W. McCain	7113 Howard Ave. Hammond, Indiana 46324	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of Cemetery Crematory or other place)	21c LOCATION—City or Town State
XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	November 16, 1991 Memory Lane Memorial Park	Schererville, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Charles W. Wells	#1042372	☐ No XX Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Mary Solan	FD#1004097	SOLAN FUNERAL HOME FH#83002893 7109 Calumet Ave., Hammond, Ind. 46324

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. Glioblastoma

DUE TO (OR AS A CONSEQUENCE OF)

b. Seizure disorder

DUE TO (OR AS A CONSEQUENCE OF)

c. Brain Tumor.

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

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

CERTIFIER

29a CERTIFIER (Check only one)

XX 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
Sirajuddin Khaja M.D.	01032657	November 14, 1991

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Sirajuddin Khaja M.D. 921 Fran-Lin Parkway Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Franklin D. Jemudes M.D.	November 15, 1991

CORONER 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 ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	JAN 13 1992

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc.
	Diana K. Carlson AUDITOR LAKE COUNTY

503B

SBH06 004 State Form 10110 (R2/3 89) DIA CERT REV

503 B