Local No. 2135-91 92005853

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Dorothy May Koonce
2. SEX	Female
3a. TIME OF DEATH	11:40A.M.
3b. DATE OF DEATH (Month, Day, Yr)	October 21, 1991
4. SOCIAL SECURITY NUMBER	304-34-4866
5a. AGE—Last Birthday (Years)	59
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	MAY 9, 1932
7. BIRTHPLACE (City and State or Foreign Country)	St. John, IN
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)	26 Walnut Parkway
9c. CITY, TOWN, OR LOCATION OF DEATH	Crown Point
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Husband: Harold L. Koonce
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Housewife
12b. KIND OF BUSINESS/INDUSTRY	At Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Crown Point
13d. STREET AND NUMBER	26 Walnut Pkwy.
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	11

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Arthur Struebig
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Susie Backe

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Harold Koonce Sr.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	26 Walnut Parkway, Crown Point, IN 46307
20c. Relationship	Husband

DISPOSITION

Field	Entry
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)	Oct 24, 1991 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State	Schererville, IN
22a. EMBALMER'S NAME	Larry A. Geisen
22b. EMBALMER'S LICENSE NO.	FD09000013
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature] Robert P. Geisen
24b. LICENSE NUMBER (of Licensee)	FD01000328
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FD83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Carcinoma Colon	6 mths
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.

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

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	29392
29d. DATE SIGNED (Month, Day, Year)	10/21/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dalal Harsh M. D., 3229 Broadway, Suite 104, Gary, IN 46409

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year)	October 23, 1991

CORONER USE ONLY

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

Handwritten in margin: Lot 14 Walnut Gardens Key # 9-215-14-

600

01446

JAN 29 1992

Alexander S. Antonas AUDITOR LAKE COUNTY

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