FA-4918 pl

Local No. 1902-91 920071130

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Return to:
First American Title Insurance Company
5265 Commerce Drive
Crown Point, IN 46307

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): DOROTHY E. MILITARY		2. SEX: FEMALE	3a. TIME OF DEATH: 4:45 A.M.	3b. DATE OF DEATH (Month Day Yr.): SEPTEMBER 12, 1991
4. SOCIAL SECURITY NUMBER: 358-10-0674	5a. AGE—Last Birthday (Years): 77	5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo. Day Yr.): September 29, 1913	7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A US VETERAN? No	8b. YEAR LAST SERVED IN US ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA	OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)	
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL		9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER		9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Widowed	11. SURVIVING SPOUSE (If wife, give maiden name): N/A	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker		12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Hammond		13d. STREET AND NUMBER: 6714 Ohio Avenue
13e. ZIP CODE: 46323	13f. INSIDE CITY LIMITS: [ ] No [X] Yes; 13g. ON A FARM? [X] No [ ] Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Bernard L. Lindstead	19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen McGregor

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mr. Joseph Military	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9112 Chestnut Ln. Munster, IN 46321	20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [ ] Cremation [X] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 16, 1991 St. John Mausoleum	21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Charles D. Scheuer, Jr.	22b. EMBALMER'S LICENSE NO.: 1006049	23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John V. Huber (signature)	24b. LICENSE NUMBER (of Licensee): 1045362	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: VIRGIL HUBER Funeral Home-3002869 7051 Kennedy, Hammond, IN 46323

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. Congestive Heart Failure	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

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

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Carcinoma of B...	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): N/A

SEP 17 1991

FILED

JAN 31 1992

CERTIFIER

29a. CERTIFIER (Check only one)
- [X] 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) as stated.

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER: Frank Hieber / Irene N. Anton, Deputy Lake County	29c. MEDICAL LICENSE NO.: 19344	29d. DATE SIGNED (Month Day Year): SEPTEMBER 16 1991

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. FRANK HIEBER, M. D. 7550 HOHMAN AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD	32. DATE FILED (Month, Day, Year): Sept. 12, 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)	01584
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

Anne Gardens Lt 4 Bl 6 #32-219-4

600 fa

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