92008214

4CC'D

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 3303-91

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	RALPH J. WESLEY
2 SEX	Male
3a TIME OF DEATH	5:15PM
3b DATE OF DEATH (Month Day Yr)	December 30, 1991
4 SOCIAL SECURITY NUMBER	303-24-6389
5a AGE—Last Birthday (Years)	73
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	APR 12, 1918
7 BIRTHPLACE (City and State or Foreign Country)	HOBART, INDIANA
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)	ST. MARY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH	HOBART
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	FLORENCE M. WYANT
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	TRUCK DRIVER
12b KIND OF BUSINESS/INDUSTRY	SHEARER & SON
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN, OR LOCATION	HOBART
13d STREET AND NUMBER	852 STATE STREET
13e ZIP CODE	46342
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc (Specify)	WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	7
College (1-4 or 5+)	

PARENTS

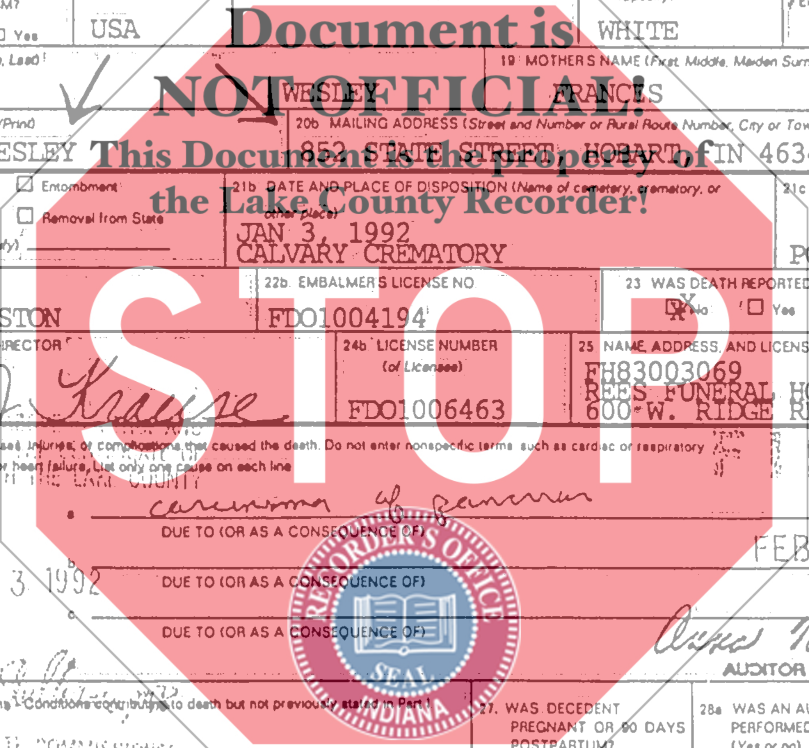
Field	Entry
18 FATHER'S NAME (First, Middle, Last)	JOHN WESLEY
19 MOTHER'S NAME (First, Middle, Maiden Surname)	FRANCES MATTMILLER

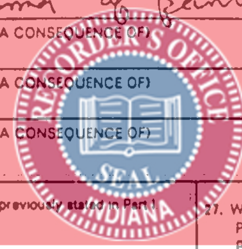
INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	FLORENCE M. WESLEY
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	852 STATE STREET, HOBART, IN 46342
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	JAN 3, 1992 CALVARY CREMATORY
21c LOCATION—City or Town, State	PORTAGE, INDIANA
22a EMBALMER'S NAME	JAMES W. GHOLSTON
22b EMBALMER'S LICENSE NO.	FDO1004194
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	James J. Krause (signature)
24b LICENSE NUMBER (of Licensee)	FDO1006463
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342





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 of pancreas	9 months
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

FILED
DEATH CERTIFICATE WITH THE LAKE COUNTY HEALTH DEPT
JAN 03 1992
FEB 7 1992
Alexander S. Williams (signature)
LAKE COUNTY HEALTH COMMISSIONER
Oscar N. Anton (signature)
AUDITOR LAKE COUNTY

Field	Entry
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)	N/A
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

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) and manner as stated.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Donald M. Phillips MD (signature)
29c MEDICAL LICENSE NO.	01020846
29d DATE SIGNED (Month, Day, Year)	12/31/91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DONALD M. PHILLIPS MD, 1356 SOUTH LAKE PARK AVE., HOBART, IN 46342

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD (signature)
32 DATE FILED (Month, Day, Year)	Jan 3, 1992

CORONER USE ONLY

Field	Entry
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	

00359

Cey #17-31-18 (handwritten)

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