INDIANA STATE BOARD OF HEALTH

4P457046 LD ①

Local No. 2071-91

92003017

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Christina Catherine Davies

2 SEX: Female

3a TIME OF DEATH: 11:20P M

3b DATE OF DEATH (Month Day, Yr): January 28, 1991

4 SOCIAL SECURITY NUMBER: 310-36-7358

5a AGE—Last Birthday (Years): 54

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Minutes):

6 DATE OF BIRTH (Mo Day, Yr): NOV 4, 1936

7 BIRTHPLACE (City and State or Foreign Country): Bruceville, IN

8a WAS DECEDENT A U.S. VETERAN?: No

8b YEAR LAST SERVED IN US ARMED FORCES?:

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): 609 W. North Street

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): Edward Leslie Davies

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

12b KIND OF BUSINESS/INDUSTRY: C.P. Civil Defense

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Crown Point

13d STREET AND NUMBER: 609 W. North St.

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?: ☒ 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): ; College (1-4 or 5+): 1

PARENTS

18 FATHER'S NAME (First Middle Last): Joseph Oliphant

19 MOTHER'S NAME (First Middle Maiden Surname): Silney Tipsiword

INFORMANT

20a INFORMANT'S NAME (Type/Print): Edward Leslie Davies

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 W. North St, Crown Point, IN 46307

20c Relationship: Husband

DISPOSITION

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

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JAN 31, 1991 ... Park ...

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

22a EMBALMER'S NAME: Robert P. Geisen

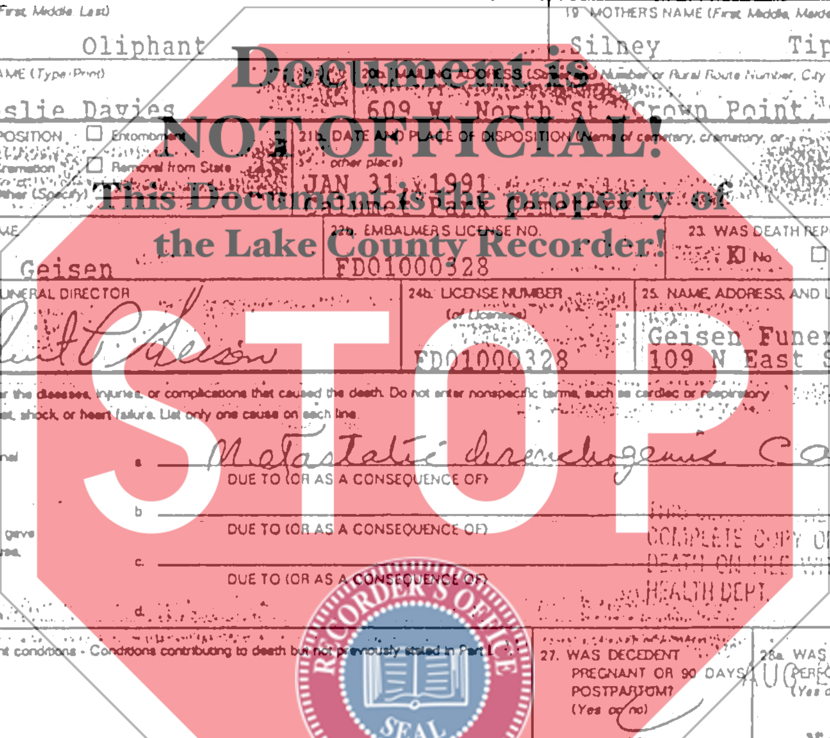
22b EMBALMER'S LICENSE NO.: FD01000328

23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FD01000328

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. - FD8300125, 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Metastatic bronchogenic Cancer

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

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

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)

28a WAS AN AUTOPSY PERFORMED? (Yes or no): No

AUG ... 1991

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: [signature]

29c MEDICAL LICENSE NO: 27970

29d DATE SIGNED (Month, Day, Year): 1/29/91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. D. Gailani M.D., 9116 Columbia Avenue, Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Robert Guthrie MD

32 DATE FILED (Month, Day, Year): Jan 30, 1991

CORONER USE ONLY

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): FEB

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.

AUDITOR LAKE COUNTY

00353

600 CK

CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION

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

1-334-37