

92013034

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Wilbert O. Schneid, 2855 W. 5th Pl. State No. 46410

Local No. 1011-91

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) Agnes J. Martin				2 SEX Female	3a TIME OF DEATH 6:19 A.M.	3b DATE OF DEATH (Month, Day, Year) May 13, 1991
4 SOCIAL SECURITY NUMBER 310-22-6443		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) Apr. 3, 1913	7 BIRTHPLACE (City and State or Foreign Country) Hegewisch, Illinois
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 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
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) Home Maker		12b KIND OF BUSINESS/INDUSTRY Own Home
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Griffith		13d STREET AND NUMBER 625 N. Lindberg
13e ZIP CODE 46319		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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) 12		18 FATHER'S NAME (First, Middle, Last) William P. O'Malley		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Leticia Campbell		20a INFORMANT'S NAME (Type, Print) Debra Martin		20b MAILING ADDRESS (Street and Number or R.F.D. Route Number, City or Town, State, Zip Code) 1620 Augusta Ct. Kokomo, Indiana		20c Relationship Daughter
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Elmwood Cemetery		21c LOCATION—City, Town, State Hammond, Indiana		
22a EMBALMER'S NAME David Peterson		22b EMBALMER'S LICENSE NO. FDO 8601585		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500		
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. Sepsis Shock of pneumonia						
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF)						
CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF) Chronic lymphocytic leukemia						
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) NO		28c YES TO POSTMORTEM FINDINGS PERFORMED (ALDOR LAKE COUNTY) NO
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 <i>[Signature]</i>				29c MEDICAL LICENSE NO. 27970		29d DATE SIGNED (Month, Day, Year) May 13, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Salman Gailani 9116 Columbia Ave. Munster, IN 46321						
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>					32 DATE FILED (Month, Day, Year) May 14, 1991	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d DESCRIBE HOW INJURY OCCURRED				
34g DATE PRONOUNCED DEAD (Month, Day, Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

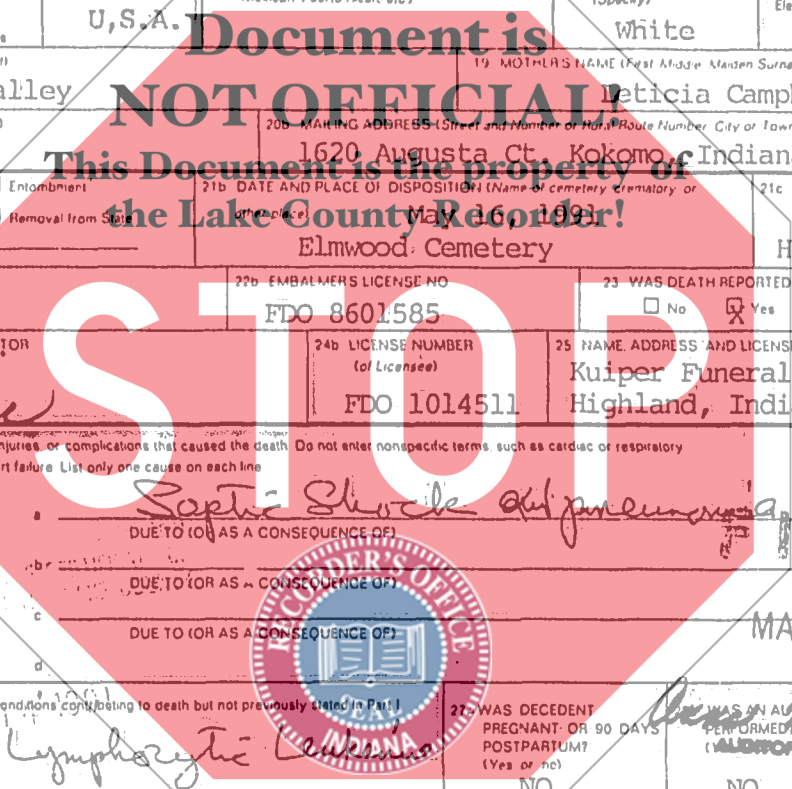
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

26-194-28
At 28 BLU
Park Manor 1st. At 28 BLU



FILED

MAR 3 1992

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