Hessville Gardens L.6 Bl.1 Key# 34-71-6 ; Unit # 26

ROGER MOORE

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Nov 21, 1991
Date Issued

Franklin D. Jemerud M.D.
Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 950 92021929

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Kenneth Shears
2 SEX: Male
3a TIME OF DEATH: 4:41 A.M.
3b DATE OF DEATH (Month Day Yr): November 21, 1991
4 SOCIAL SECURITY NUMBER: 506-12-4733
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): NOVEMBER13, 1914
7 BIRTHPLACE (City and State or Foreign Country): CHERRY CO. NEBRASKA
8a WAS DECEDENT A US VETERAN?: YES
8b YEAR LAST SERVED IN US ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution give street and number): St. Margaret Hospital
9c CITY TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Rhoda Collier
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Inspector
12b KIND OF BUSINESS/INDUSTRY: Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 2944 165th Street
13e ZIP CODE: 46323
13f INSIDE CITY LIMITS [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 8; College (1-4 or 5 +):

PARENTS

18 FATHERS NAME (First Middle Last): William Shears
19 MOTHERS NAME (First Middle Maiden Surname): Mary Gambill

INFORMANT

20a INFORMANT'S NAME (Type/Print): Rhoda Shears
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State Zip Code): 2944 165th Street Hammond, IN 46323
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): November 23, 1991
21c LOCATION—City or Town State: Park Forest Crematorium Park Forest, Illinois
22a EMBALMER'S NAME: None
22b EMBALMER'S LICENSE NO: N/A
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD01013507
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home Inc. FH83002801 7042 Kennedy Ave. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Severe coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF): c. congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF): d.

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

Approximate Interval Between Onset and Death

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: right above knee amputation

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): No

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

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 31576
29d DATE SIGNED (Month Day Year): NOV. 21. '91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W. Loh, M. D. 9108 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jemerud L.C.M.E.
32 DATE FILED (Month Day Year): November 21, 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 Ooccurred:
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:

APR 10 1992

6.00

Alex N. Beben
AUDITOR LAKE COUNTY

00625

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