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92033678

Local No. 1040-92

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Sue O. Meyer
2. SEX: Female
3a. TIME OF DEATH: 12:21am
3b. DATE OF DEATH (Month, Day, Yr): May 8, 1992
4. SOCIAL SECURITY NUMBER: 416-20-0728
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Feb. 27, 1918
7. BIRTHPLACE (City and State or Foreign Country): Eoline, Alabama
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. 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): 4529 Rutledge St.
9c. CITY, TOWN, OR LOCATION OF DEATH: Calumet Township
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Alfred Meyer
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Calumet Township
13d. STREET AND NUMBER: 4529 Rutledge St.
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 12; College (1-4 or 5+): —

PARENTS

18. FATHER'S NAME (First, Middle, Last): Isaac Owens
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Showers

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Alfred Meyer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4529 Rutledge St. Gary, In 46408
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 11, 1992 Chapel Lawn Cemetery
21c. LOCATION—City or Town, State: Schererville, Ind.
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes XX
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr.
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. Home FH 83007819 5100 Cleveland St. Gary, In 46408

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. Acute Myocardial Infarction
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.

PART II. Other significant conditions contributing to death but not previously stated in Part I: Chronic Obstructive Lung Disease

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
MAY 27 1992
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

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 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] MD
29c. MEDICAL LICENSE NO.: 27402
29d. DATE SIGNED (Month, Day, Year): May 11, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): C. Castor M.D. 911-A Fran Lin Pkwy, Munster, Ind 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): May 15, 1992

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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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