20 CC's 92035988

Local No. 0589-92

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

L. 61 KEY # 15-146-18 Independence Hill 3RD ADD

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Elizabeth J. Holmes
2 SEX	Female
3a TIME OF DEATH	10:02 A M
3b DATE OF DEATH (Month Day Year)	March 11, 1992
4 SOCIAL SECURITY NUMBER	316-24-9101
5a AGE—Last Birthday (Years)	64
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	September 6,1927
7 BIRTHPLACE (City and State or Foreign Country)	Tuscola, Illinois
8a WAS DECEDENT A U S VETERAN?	----
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 ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number)	St. Anthony Medical Center
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)	Robert C. Holmes
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	Homemaker
12b KIND OF BUSINESS/INDUSTRY	Self
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY TOWN OR LOCATION	Merrillville
13d STREET AND NUMBER	8415 Ellsworth Place
13e ZIP CODE	46410
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	☒ No ☐ Yes
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+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	James Edward Adams
19 MOTHER'S NAME (First Middle Maiden Surname)	Joy Moore

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type Print)	Robert C. Holmes
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8415 Ellsworth Pl. Merrillville, In. 46410
20c Relationship	Husband

DISPOSITION

Field	Entry
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)	March 13, 1992 Evergreen Memorial Park Calumet Park Cemetery
21c LOCATION—City or Town State	Hobart, Indiana-Burial Merrillville, Indiana
22a EMBALMER'S NAME	------
22b EMBALMER'S LICENSE NO	------
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Robert A. Craig Jr.
24b LICENSE NUMBER (of Licensee)	FD08700735
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410

THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPT.

MAR 12 1992

Alexander S. Williams MD

LAKE COUNTY HEALTH COMMISSIONER

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	Acute Renal failure	
DUE TO (OR AS A CONSEQUENCE OF) b	Ischemic heart Disease with Acute MI-	
DUE TO (OR AS A CONSEQUENCE OF) c	Atherosclerosis	
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 - Conditions contributing to death but not resulting in the underlying cause given in Part I

Field	Entry
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

ROBERT ... JUN 4 1992 ... FILED ... STATE ...

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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Vidyadhar R. Gandra
29c MEDICAL LICENSE NO	29999
29d DATE SIGNED (Month Day Year)	March 11, 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Vidyadhar Gandra, M.D., 297 Franciscan Drive, Crown Point, Indiana 46307

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD
32 DATE FILED (Month Day Year)	March 12, 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	

FILED JUN 4 1992

Anna N. Antone

AUDITOR LAKE COUNTY

600

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

00380