6) CC's

Tax Key Number 0001766489

William J. Longer
651 East 3rd St.
Hobart 46342

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1102-92
92039320

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): NINA E. HALVORSON
2. SEX: FEMALE
3a. TIME OF DEATH: 2:24 A.M.
3b. DATE OF DEATH (Month Day Yr): MAY 21, 1992
4. SOCIAL SECURITY NUMBER: 471-16-7340
5a. AGE—Last Birthday (Years): 80
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): FEB. 17, 1912
7. BIRTHPLACE (City and State or Foreign Country): DULUTH, MINNESOTA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NONE
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): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): DONALD G. HALVORSON
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: AT HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 1102 STATE STREET
13e. ZIP CODE: 46342
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?: ☒ 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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): THOMAS I. THOMPSON
19. MOTHER'S NAME (First, Middle, Maiden Surname): CLARA JOHNSON

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DONALD G. HALVORSON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 STATE STREET, HOBART, INDIANA, 46342
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): MAY 23, 1992 N.W. INDIANA CREMATION SERVICE
21c. LOCATION—City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO.: 101071
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH# 83002380 701 E. 7th STREET, HOBART, INDIANA 46342

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): Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF): ASHD
DUE TO (OR AS A CONSEQUENCE OF): recent CVA & hemiplegia
DUE TO (OR AS A CONSEQUENCE OF): recent intermittent bowel obstruction
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 contributing to death but not resulting in the underlying cause given in Part I.
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

THIS CERTIFIES THAT THIS IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
MAY 21 1992
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
JUN 17 1992
Anna N. Anton
AUDITOR LAKE COUNTY

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: Robert R. Wylie MD
29c. MEDICAL LICENSE NO.: 20894
29d. DATE SIGNED (Month, Day, Year): 5/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ROBERT R. WYLIE, M.D., 1400 S. LAKE PARK, HOBART, INDIANA, 46342 (942-7299)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): May 21, 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