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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1312-92 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First Middle Last)	JOYCE E. HICKS
2. SEX	Female
3a. TIME OF DEATH	4:58AM
3b. DATE OF DEATH (Month Day Yr)	June 16, 1992
4. SOCIAL SECURITY NUMBER	312-44-0477
5a. AGE—Last Birthday (Years)	49
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo Day, Yr)	SEP 18, 1942
7. BIRTHPLACE (City and State or Foreign Country)	KEYSPORT, PENNSYLVANIA
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	3807 BARNES STREET
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)	JACK G. HICKS
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	N/A
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HOBART
13d. STREET AND NUMBER	3807 BARNES STREET
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
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+)	10

PARENTS

Field	Value
18. FATHER'S NAME (First Middle Last)	LESTER N. ZERBY
19. MOTHER'S NAME (First Middle Maiden Surname)	BETTY J. BROWN

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	JACK G. HICKS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3807 BARNES STREET, HOBART, IN 46342
20c. Relationship	Husband

DISPOSITION

Field	Value
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)	JUN 18, 1992 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State	SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME	JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.	FDO1004194
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FDO1006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 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. Approximate Interval Between Onset and Death

THIS CERTIFIES THE ABOVE ... ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Lung Cancer

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

JUN 17 1992

JUN 22 1992

PART II Other significant conditions - Conditions contributing to death but not previously related in Part I: Alexander S. Williams, M.D.

LAKE COUNTY HEALTH DEPT.

Field	Value
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)	N/A

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.

Field	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	R. S. Drasga
29c. MEDICAL LICENSE NO.	01031484
29d. DATE SIGNED (Month, Day, Year)	6/17/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	RAY E. DRASGA MD, 8127 MERRILLVILLE RD., MERRILLVILLE, IN 46410

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year)	June 17, 1992

CORONER USE ONLY

Field	Value
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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 I Rees Funeral Home 600 W Ridge Hobart 46342

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