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4066 Willow ST Hobart, IN 46342

# PORTER COUNTY BOARD OF HEALTH
# MEDICAL CERTIFICATE OF DEATH

tax mailing address: 4066 Willow, Hobart, IN 46342

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1. DECEASED—NAME (First, Middle, Last) | | | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr) |
|---|---|---|---|---|---|
| MYRA | E. | WILSON | Female | 6:30P | October 26, 1992 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR (Months / Days) | 5c. UNDER 1 DAY (Hours / Minutes) | 6. DATE OF BIRTH (Day, Yr) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 314-18-3753 | 76 | | | OCT 10, 1916 | CRYSTAL, MICHIGAN |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9. PLACE OF DEATH (Check only one) (See instructions) |
|---|---|---|
| No | N/A | HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; [ ] Nursing Home [ ] Other (Specify); [ ] Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| PORTER MEMORIAL HOSPITAL | VALPARAISO | PORTER |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Widowed | NONE | HOMEMAKER | N/A |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | PORTER | VALPARAISO | 1000 E. ELIZABETH ST. |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| 46383 | [X] No [ ] Yes | [X] No [ ] Yes | USA | [X] No [ ] Yes | WHITE | 8 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| MYRON PELTON | MILDRED SMITH |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| SHARON FLICK | 4054 WILLOW, HOBART, IN 46342 | Daughter |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) | OCT 29, 1992 EVERGREEN MEMORIAL PARK | HOBART, INDIANA |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| JAMES J. KRAUSE | FD01006463 | [X] No [ ] Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| James J. Krause | FD01006463 | FH83003069 REES FUNERAL HOMES INC 600 W. RIDGE RD, HOBART, IN 46342 |

**CAUSE OF DEATH**

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. - Metastatic Adenocarcinoma | |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | b. DUE TO (OR AS A CONSEQUENCE OF): - Pulmonary Emboli | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

- Melanoma
- CVA

| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| NO | No | N/A |

**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 | 29c. MEDICAL LICENSE NO | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | 01024990 | October 29 92 |

**HEALTH OFFICER**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print)

JOHN P. SWARNER M.D., 1101 EAST GLENDALE, VALPARAISO, IN 46383

31. HEALTH OFFICER'S SIGNATURE: Dalyn A. Schenker, M.D.

FILED

32. DATE FILED (Month, Day, Year): October 30 1992

**CORONER USE ONLY**

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide | | | NOV 4 1992 | |

| 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) |
|---|---|
| | Anne N. Anton AUDITOR LAKE COUNTY |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. |
|---|---|
| | 00245 |