

Pauline M. Choate 71

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 93013826
3769-92.....

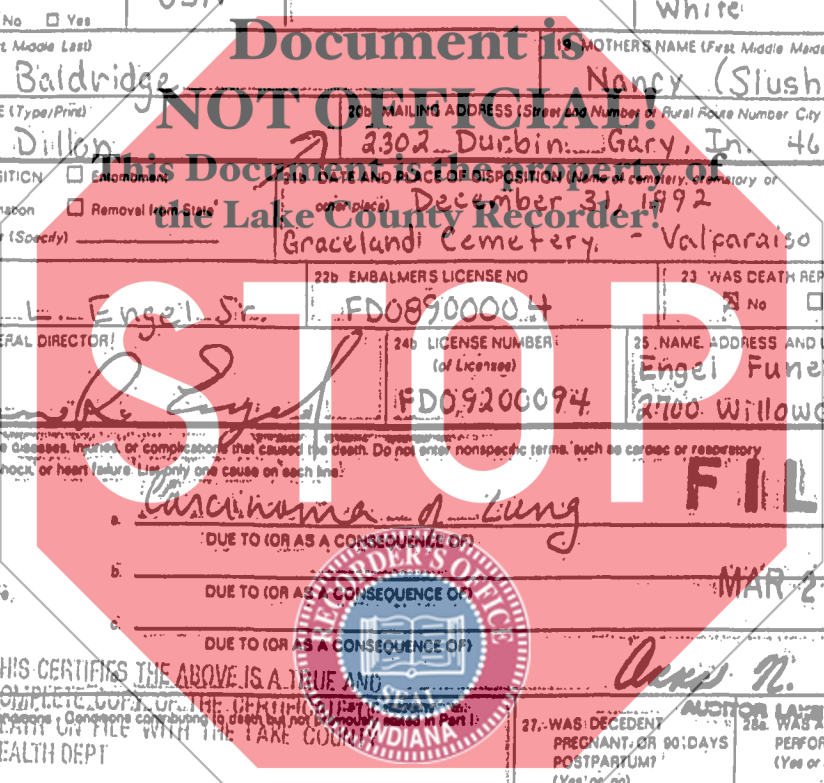
State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN:
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) BEATRICE DILLON		2 SEX FEMALE		3a TIME OF DEATH 10:05 A.		3b DATE OF DEATH (Month Day Year) DECEMBER 29, 1992	
4 SOCIAL SECURITY NUMBER 406-36-7018		5a AGE—Last Birthday (Years) 66		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) September 13, 1927		7 BIRTHPLACE (City and State or Foreign Country) Morehead, Kentucky					
8a WAS DECEDENT A US VETERAN? No		8b YEAR LAST SERVED IN US ARMED FORCES?		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not mention give street and number) THE COMMUNITY HOSPITAL				9c CITY TOWN OR LOCATION OF DEATH MUNSTER		9d COUNTY OF DEATH OS LAKE	
10 MARITAL STATUS (Specify) Widowed		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) Homemaker		12b KIND OF BUSINESS/INDUSTRY Home	
13a RESIDENCE—STATE In.		13b COUNTY Lake		13c CITY TOWN OR LOCATION Gary		13d STREET AND NUMBER 2302 Durbin	
13e ZIP CODE 46401		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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) HS		18 FATHER'S NAME (First Middle Last) Andy Baldridge		19 MOTHER'S NAME (First Middle Maiden Surname) Nancy (Slusher)	
20a INFORMANT'S NAME (Type/Print) Kenny Dillon		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 2302 Durbin Gary, In. 46401		20c Relationship Son			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) December 31, 1992 Graceland Cemetery - Valparaiso		21c LOCATION—City or Town State Valparaiso, In.			
22a EMBALMER'S NAME Kevin L. Engel Sr.		22b EMBALMER'S LICENSE NO. FD08900004		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR! <i>Kevin L. Engel Sr.</i>		24b LICENSE NUMBER (of Licensee) FD09200094		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Engel Funeral Home Rt 85007893 2700 Willowcreek Rd Portage, In.			
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. Carcinoma of Lung		26. PART II. Other significant conditions or diseases contributing to death but not primarily listed in Part I.		27. WAS DECEDENT PREGNANT, OR 90 DAYS POSTPARTUM? (Yes or no) No			
28. IMMEDIATE CAUSE (Final disease or condition resulting in death) Carcinoma of Lung		28. CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arvind N. Gandhi</i>		29c. MEDICAL LICENSE NO. 29887		29d. DATE SIGNED (Month Day Year) DECEMBER 31 1992	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print) DR. ARVIND N. GANDHI, M.D. 9122 COLUMBIA AVENUE MUNSTER, INDIANA 46321		31. HEALTH OFFICER'S SIGNATURE <i>Arvind N. Gandhi, M.D.</i>		31. DATE FILED (Month Day Year) January 8, 1993		32. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. LOCAT CN (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		00190			

49-455 15
Midway Road Ind. Rt 15 bld 3



STATE OF INDIANA
LAKE COUNTY

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