

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

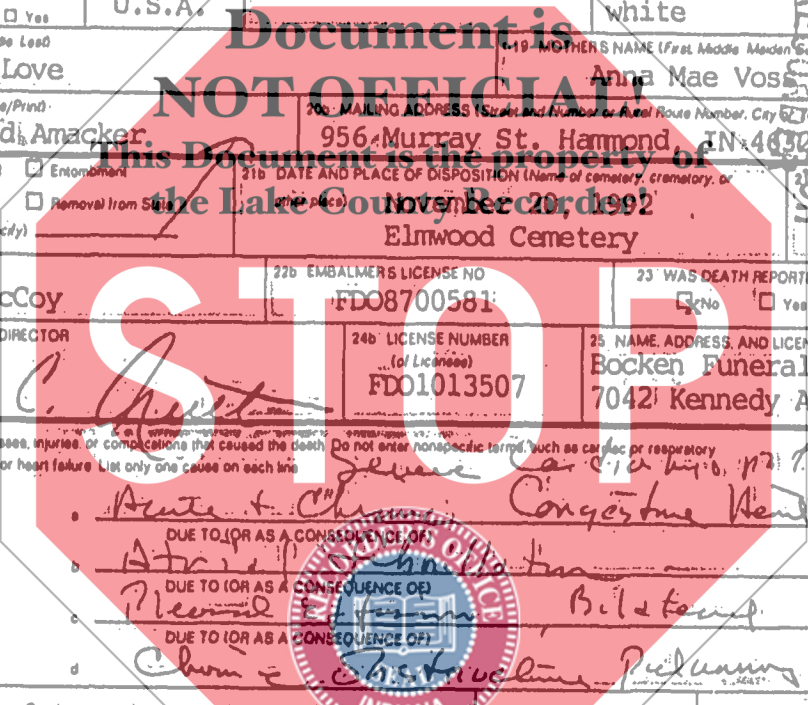
THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 989 3014236

Noted 10/19/92
Date Issued
Hammond Health Commissioner

PRINT IN PERMANENT BLACK-INK
DECEDENT
PARENTS
INFORMANT
DISPOSITION
CAUSE OF DEATH
CERTIFIER
HEALTH OFFICER
CORNER USE ONLY

1. DECEASED—NAME (First Middle Last) Virginia Amacker		2 SEX Female	3a TIME OF DEATH 1:00 A M	3b DATE OF DEATH (Month Day Yr) November 18, 1992
4 SOCIAL SECURITY NUMBER 310-62-3686	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) Jan. 17, 1921
7 BIRTHPLACE (City and State or Foreign Country) Williamsport, Tennessee	8a WAS DECEDENT A US VETERAN? no	8b YEAR LAST SERVED IN US ARMED FORCES? none	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution, give street and number) St. Margaret-Mercy Healthcare North Campus		9c CITY, TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Cleveland S. Amacker	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 Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 956 Murray Street
13e ZIP CODE 46320	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc (Specify) white
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (K-12) 12 College (1-4 or 8+) 12		18 FATHER'S NAME (First Middle Last) Andrew Love		
19 MOTHER'S NAME (First Middle Last) Anna Mae Voss		20 INFORMANT'S NAME (Type/Print) Mr. Cleveland Amacker		
20a MAILING ADDRESS (Street and Number or Rural Route Number, City, State, Zip Code) 956 Murray St. Hammond IN 46320		20b Relationship Husband		
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) Elmwood Cemetery Hammond, Indiana		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME David F. McCoy		22b EMBALMER'S LICENSE NO. FDO8700581		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24 SIGNATURE OF FUNERAL DIRECTOR <i>John C. [Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO1013507		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 70421 Kennedy Ave. Hammond, IN 46323
26 PART I: Enter the disease, 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 Acute + Chronic Congestive Heart Failure		Approximate Interval Between Onset and Death 2 yr		
IMMEDIATE CAUSE (Final disease or condition resulting in death) Acute + Chronic Congestive Heart Failure		Approximate Interval Between Onset and Death 2 yr		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last Chronic obstructive Pulmonary Disease		Approximate Interval Between Onset and Death 2 yr		
PART II: Other significant conditions - Conditions contributing to death but not previously stated by Part I Respiratory distress syndrome Ventilator Ass. 1st.		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		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 <i>Floyd Manley, MD</i>		
29c. MEDICAL LICENSE NO. 010.19.297		29d. DATE SIGNED (Month, Day, Year) Nov. 11 - 1992		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Floyd Manley, MD 6010 Columbia Ave Hammond, Indiana 46320		31. HEALTH OFFICER'S SIGNATURE: <i>Franklin D. Remuda, M.D.</i>		
31. HEALTH OFFICER'S SIGNATURE: <i>Franklin D. Remuda, M.D.</i>		32. DATE FILED (Month, Day, Year) November 20, 1992		
33 MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) MAR 4 1993		34b TIME OF INJURY (Yes or No) FILED
34c PLACE OF INJURY—At home, farm, street, factory, office, building etc (Specify) AM		34d DESCRIBE HOW INJURY OCCURRED! 00253		
34g DATE PRONOUNCED DEAD (Month, Day, Year) Nov 18 1992		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. None N. Antonio		



32-177-16 Cottage Grove Rd E-33
TKS: SAME

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