2nd West Park Add L.6, Bl.11

Key#36-315-6

# INDIANA STATE DEPARTMENT OF HEALTH

Local No. Unit#26 93015288 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First Middle Last): ALICE . . SHIMALA | 2 SEX: F | 3a TIME OF DEATH: C.20P M | 3b DATE OF DEATH (Month Day Yr): January 22,1993

4 SOCIAL SECURITY NUMBER: 312-01-0302 | 5a AGE—Last Birthday (Years): 76 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Mo Day Yr): Feb. 15,1916 | 7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois

8a WAS DECEDENT A U.S. VETERAN?: No | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?: n/a | 8c 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. Catherine Hospital | 9c CITY, TOWN OR LOCATION OF DEATH: East Chicago | 9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married | 11 SURVIVING SPOUSE (If wife, give maiden name): Charles J. Shimala | 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 (Whiting P.O.) | 13d STREET AND NUMBER: 2022 Davis Avenue

13e ZIP CODE: 46394 | 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): 12 | College (1-4 or 5+):

**PARENTS**

18 FATHER'S NAME (First Middle Last): Gene Nelson | 19 MOTHER'S NAME (First Middle Maiden Surname): Irene Apple

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Mr. Charles J. Shimala | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2022 Davis Avenue, Hammond, IN 46394 | 20c Relationship: Husband

**DISPOSITION**

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify) | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory, or other place): January 26,1993 St. John Cemetery | 21c LOCATION—City or Town State: Hammond, Indiana

22a EMBALMER'S NAME: Martin A. Dybel | 22b EMBALMER'S LICENSE NO: FD001019456 | 23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature] | 24b LICENSE NUMBER (or License): FD001019456 | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc., FDH83007267 1235-119th, Whiting, IN 46394

**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): a. Central nervous system lymphoma

DUE TO (OR AS A CONSEQUENCE OF): b. Malignant lymphoma

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death:

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): n/a

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

**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: David A. Buchanan MD | 29c MEDICAL LICENSE NO: 035497 | 29d DATE SIGNED (Month Day Year): Jan. 25,1993

**HEALTH OFFICER**

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): David A. Buchanan, M.D., 1712 Magoun Avenue, EastChicago, IN 46312

31 HEALTH OFFICER'S SIGNATURE: [signature] | 32 DATE FILED (Month, Day, Year): 01-26-1993

**CORONER USE ONLY**

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): MAR 9 1993 | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) | Yes, Specify driver passenger

AUDITOR LAKE COUNTY

600

00447

SDH06-004 State Form 10110 (R-1-92) DEATHCER/PD1