

93015527

INDIANA STATE BOARD OF HEALTH

Roger Smith Unit 2

Local No. 098-92

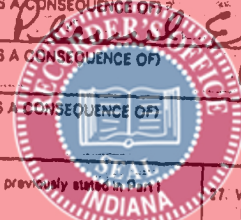
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Clarence O. White		2 SEX Male	3a TIME OF DEATH 11:20 A.M.	3b DATE OF DEATH (Month Day Year) January 13, 1992
4 SOCIAL SECURITY NUMBER 306-01-8912	5a AGE—Last Birthday (Years) 85	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	8 DATE OF BIRTH (Mo Day Yr) Nov. 21, 1906
6a WAS DECEDENT A US VETERAN? NO	6b YEAR LAST SERVED IN US ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify):		
9b FACILITY NAME (If not institution, give street and number) 144 Plum Creek Dr.		9c CITY, TOWN, OR LOCATION OF DEATH Schererville	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ruth Doss	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Welder		12b KIND OF BUSINESS/INDUSTRY Oil Co.
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Schererville	13d STREET AND NUMBER 144 Plum Creek Dr.	
13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) White
18 FATHER'S NAME (First Middle Last) Sebron White		19 MOTHER'S NAME (First Middle Maiden Surname) Anna Kvarck		
20a INFORMANT'S NAME (Type/Print) Ruth White		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Plum Creek Dr., Schererville, Indiana		20c Relationship Wife
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 (Specify cemetery, crematory, or other place) January 16, 1992 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, Indiana
22a EMBALMER'S NAME Raymond White		22b EMBALMER'S LICENSE NO. FDO#8700086	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of License) FDO 1014511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500	
26 PART I Enter the disease, injury, 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. <p>a. Right Mesothelioma DUE TO (OR AS A CONSEQUENCE OF) _____</p> <p>b. Right Pleural Effusion DUE TO (OR AS A CONSEQUENCE OF) _____</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF) _____</p> <p>d. _____</p>				
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Chronic Mesothelioma				
27a CERTIFIER'S NAME (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) as stated		27b WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		27c AUTOPSY PERFORMED? (Yes or no) NO
28a SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) <input checked="" type="checkbox"/>	28c APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 110 K Morrissey M.D.		29a MEDICAL LICENSE NO. 28441	29b DATE SIGNED (Month, Day, Year) Jan 14/92	
30 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> M.D.		31 DATE FILED (Month, Day, Year) January 15, 1992		
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 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.		34i		

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FILED MAR 10 1993

THIS DEATH IS COMPLETELY DEPENDENT ON THE CAUSE OF DEATH LISTED

LAKE COUNTY

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

SBH06-004 State Form 10110 (R2/3-89) DEACERT/PO 13-335-1 (In Broken Condominiums 3/10/93 by Build II Unit I Ossin Inc. R 8 Plum Creek Village Bl 3