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Key # 9 . 32C 3, unit # 23

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93021003

PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): ALICE M. EDWARDS
2 SEX: Female
3a TIME OF DEATH: 7:00 P M
3b DATE OF DEATH (Month Day Yr): January 16, 1992
4 SOCIAL SECURITY NUMBER: 313-54-8960
5a AGE—Last Birthday (Years): 91
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): March 22, 1900
7 BIRTHPLACE (City and State or Foreign Country): Deer Creek County, Iowa
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER XX Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): Fountainview Nursing Home
9c CITY TOWN OR LOCATION OF DEATH: Portage
9d COUNTY OF DEATH: Porter
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: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Crown Point
13d STREET AND NUMBER: 340 West Goldsborough
13e ZIP CODE: 46307
13f INSIDE CITY LIMITS: ☐ No XX Yes
13g ON A FARM?: XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.): XX No ☐ Yes
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+): 1

PARENTS

18 FATHER'S NAME (First Middle Last): Bert Shuster
19 MOTHER'S NAME (First Middle Maiden Surname): May Brabbit

INFORMANT

20a INFORMANT'S NAME (Type/Print): Bert Edwards
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 340 W. Goldsborough, Crown Point, IN 46307
20c. Relationship: Son.

for mailing address

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 20, 1992 Calvary Cemetery
21c LOCATION—City or Town, State: Portage, Indiana
22a EMBALMER'S NAME: Dean G. Wagner
22b EMBALMER'S LICENSE NO.: 8800057
23 WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 1007231
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

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. ARTERIO SCLEROTIC HEART DISEASE — Approximate Interval Between Onset and Death: 1 YEAR

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

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

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

CERTIFIER

29a CERTIFIER (Check only one):
XX 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: A Abey MD
29c MEDICAL LICENSE NO: 01030830
29d DATE SIGNED (Month Day, Year): 1.17.92

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Annesley Abey, M.D., 6040 Lute Road, Portage, Indiana 46368

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD
32 DATE FILED (Month Day, Year): January 17, 1992

FILED

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a DATE OF INJURY (Month, Day, Year):
34b TIME OF INJURY:
34c INJURY AT WORK? (Yes or no):
34d DESCRIBE HOW INJURY OCCURRED:

APR 2 1993

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):

[signature] Anna N. Antonie

34g DATE PRONOUNCED DEAD (Month Day, Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes ... etc

AUDITOR LAKE COUNTY

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT