INDIANA STATE DEPARTMENT OF HEALTH

Local No: 93026048 CERTIFICATE OF DEATH State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Bert Lewis Newman

2 SEX: Male

3a TIME OF DEATH: 4:54 PM

3b DATE OF DEATH (Month Day Yr): March 22, 1993

4 SOCIAL SECURITY NUMBER: 313-07-3190

5a AGE—Last Birthday (Years): 83

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo Day Yr): Jan. 13, 1910

7 BIRTHPLACE (City and State or Foreign Country): Hartford City, IN.

8a WAS DECEDENT A U.S. VETERAN? No

8b YEAR LAST SERVED IN U.S. ARMED FORCES? None

9a PLACE OF DEATH (Check only one See instructions)

HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA

OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution give street and number): St. Anthony's Medical Center

9c CITY TOWN OR LOCATION OF DEATH: Crown Point

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Florence Justice

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Electric Meter Tech

12b KIND OF BUSINESS/INDUSTRY: N.I.P.S.C.O.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Merrillville

13d STREET AND NUMBER: 7320 Taft St.

13e ZIP CODE: 46410

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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 +): 3

PARENTS

18 FATHER'S NAME (First Middle Last): Bert Calvin Newman

19 MOTHER'S NAME (First Middle Maiden Surname): Emma Rhoten

INFORMANT

20a INFORMANT'S NAME (Type/Print): Florence Newman

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 7320 Taft Merrillville, IN. 46410

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): March 26, 1993

21c LOCATION—City or Town State: Calumet Park Cemetery Merrillville, IN.

22a EMBALMER'S NAME: David Sempinski

22b EMBALMER'S LICENSE NO: FD08600686

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik

24b LICENSE NUMBER (of Licensee): FD0100293

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Stilinovich & Wiatrolik FH300445 7535 Taft Merrillville, IN. 46410

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

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 failure List only one cause on each line

Approximate Interval Between Onset and Death

Immediate cause (Final disease or condition resulting in death): a. End-Stage Parkinson's Disease — 12 years

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.

APR 0 1993

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

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

LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

29a CERTIFIER (Check only one)

[X] 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: Larry M. Salberg MD

29c MEDICAL LICENSE NO: 01025163

29d DATE SIGNED (Month Day Year): 3/29/93

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Salberg 521 E. 86th Avenue Merrillville, IN. 46410 769-0777

31 HEALTH OFFICER'S SIGNATURE: Alexander L. Williams MD

32 DATE FILED (Month Day Year): April 1, 1993

FILED

APR 23 1993

AUDITOR LAKE COUNTY

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

34e PLACE OF INJURY—At home farm street factory office building etc (Specify)

34f DESCRIPTION (Street 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

01312

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER PD 1