10cc

Stuart + Swenson
118 Park Manor Dr.
Dyer 46311
71

93040108

Local No. 1069-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): JOHN HERBERT SWENSON
2. SEX: MALE
3a. TIME OF DEATH: 11:50 AM
3b. DATE OF DEATH (Month Day Yr): MAY 15, 1993
4. SOCIAL SECURITY NUMBER: 306-10-2306
5a. AGE—Last Birthday (Years): 82
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr): SEPTEMBER 18, 1910
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? ---
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE CAMPUS
9c. CITY, TOWN OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): DOROTHY STUART
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STEELWORKER (RETIRED)
12b. KIND OF BUSINESS/INDUSTRY: U.S. STEEL CORP.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: MERRILLVILLE
13d. STREET AND NUMBER: 415 E. 72nd Avenue
13e. ZIP CODE: 46410
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): CARL E. SWENSON
19. MOTHER'S NAME (First Middle Maiden Surname): HULDA SVENSON

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DOROTHY SWENSON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 E. 72nd AVE. MERRILLVILLE, IN 46410
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 18, 1993 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE INDIANA
22a. EMBALMER'S NAME: GORDON L JONES
22b. EMBALMER'S LICENSE NO: 1010711
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P Burns
24b. LICENSE NUMBER (of Licensee): 1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home, 10101 Broadway Crown Point, In 46307 FDH83002445

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. metastatic brain tumor - 1° unknown — Approximate Interval Between Onset and Death

b. DUE TO (OR AS A CONSEQUENCE OF)

c. DUE TO (OR AS A CONSEQUENCE OF)

d. DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

MAY 18 1993

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

[signature] LAKE COUNTY HEALTH COMMISSIONER

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): NA

STATE OF INDIANA S.S.N. LAKE COUNTY FILED FOR RECORD
JUN 22 11 00 AM '93
SAMUEL ORLICH RECORDER

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: R. Cristea MD
29c. MEDICAL LICENSE NO: 01037943
29d. DATE SIGNED (Month, Day, Year): 5/17/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR RICHARD CRISTEA, 521 E. 86th Ave, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] FILED
32. DATE FILED (Month, Day, Year): May 18, 1993

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): JUN 22 1993
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): Anna N. Antonie AUDITOR LAKE COUNTY
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

CE-15-29-11

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