1 20+2

93041490

Key # 5-47-1
N 1/2 NW 1/4 S.14 T.33 R.8
8 Ac.
Key # 7-20-16
NW 1/4 Pt. 330 x 396 Ft.
S 1/2 SW 1/4 NE 1/4 S.26 T.34 R.8 3 Ac.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1592-93

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): Donald J. Ross
2. SEX: Male
3a. TIME OF DEATH: 6:40PM
3b. DATE OF DEATH (Month Day Yr): June 19, 1993
4. SOCIAL SECURITY NUMBER: 303-24-5430
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): JAN 26, 1923
7. BIRTHPLACE (City and State or Foreign Country): Crown Point, IN.
8a. WAS DECEDENT A U S VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1946
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): Phyllis Ross/Dillabaugh
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance Foreman
12b. KIND OF BUSINESS/INDUSTRY: Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 13613 Iowa St.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: [X] No [ ] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? USA
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+):

PARENTS

18. FATHER'S NAME (First Middle Last): Joseph Ross
19. MOTHER'S NAME (First Middle Maiden Surname): Mable Love

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Phyllis Ross
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13613 Iowa St., Crown Point, IN. 46307
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JUN 23, 1993 Calumet Park Cemetery
21c. LOCATION—City or Town State: Merrillville, Indiana
22a. EMBALMER'S NAME: Marty Andersen
22b. EMBALMER'S LICENSE NO: FD01005205
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: (signature)
24b. LICENSE NUMBER (of Licensee): FD09000013
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FD83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Respiratory failure — 2 days
DUE TO (OR AS A CONSEQUENCE OF)
b. Severe lung disease — 5 yrs
DUE TO (OR AS A CONSEQUENCE OF)
c. Congestive heart failure — 5 yrs
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

JUN 22 1993

PART II. Other significant conditions contributing to death but not related to cause given in Part I

(signature) M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
JUN 28 1993

27. IF FEMALE, 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

JUN 28 2 23 PM '93
SAMUEL ORLICH RECORDER
FILED FOR RECORD LAKE COUNTY

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.

AUDITOR LAKE COUNTY (stamp with signature)

29b. SIGNATURE AND TITLE OF CERTIFIER: (signature)
29c. MEDICAL LICENSE NO: 01029166
29d. DATE SIGNED (Month Day, Year): 6-22-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Hakam Safadi M. D., 8315 Virginia, Suite J, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: (signature) M.D.
32. DATE FILED (Month, Day, Year): June 22, 1993

CORONER USE ONLY

33. MANNER OF DEATH: [X] 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. 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.

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

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