93042709

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. C.G.14-93 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	PETER S. MANSON
2. SEX	MALE
3a. TIME OF DEATH	3:45 AM
3b. DATE OF DEATH (Month Day Yr)	MARCH 23, 1993
4. SOCIAL SECURITY NUMBER	306-03 8358
5a. AGE—Last Birthday (Years)	87
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	March 4, 1906
7. BIRTHPLACE (City and State or Foreign Country)	Greece
8a. WAS DECEDENT A US VETERAN?	No
8b. YEAR LAST SERVED IN US ARMED FORCES?	None
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)	THE COMMUNITY HOSPITAL
9c. CITY, TOWN OR LOCATION OF DEATH	MUNSTER
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife give maiden name)	Tessie Flaris
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Retired Businessman
12b. KIND OF BUSINESS/INDUSTRY	Grocery
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Whiting
13d. STREET AND NUMBER	1615 Davis Street
13e. ZIP CODE	46394
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? (If yes specify Cuban, Mexican, Puerto Rican, etc)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	8
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	Steve Manson
19. MOTHER'S NAME (First Middle Maiden Surname)	Joyce N/A

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Tessie Manson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1615 Davis St. Whiting, Indiana 46394
20c. Relationship	Wife

DISPOSITION

Field	Entry
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)	March 26, 1993 Elmwood Cemetery
21c. LOCATION—City or Town, State	Hammond, Ind.
22a. EMBALMER'S NAME	James Porras
22b. EMBALMER'S LICENSE NO	1045964
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Thomas J. Burns (signature)
24b. LICENSE NUMBER (of Licensee)	1045184
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home #3002819, 5840 Hohman Ave, Hammond, Ind. 46320

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	ACUTE CONGESTIVE HEART FAILURE	Days
DUE TO (OR AS A CONSEQUENCE OF) b.	CARDIOMYOPATHY	Months
DUE TO (OR AS A CONSEQUENCE OF) c.	ARTERIOSCLEROTIC HEART DISEASE	Years
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: ACUTE RENAL FAILURE

Field	Entry
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)

☒ 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Claude E. Foreit, D.O. (signature)
29c. MEDICAL LICENSE NO.	00209
29d. DATE SIGNED (Month, Day, Year)	MARCH 23, 1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. CLAUDE E. FOREIT, D. O. 3831 HOHMAN AVENUE HAMMOND, INDIANA 46327

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	
32. DATE FILED (Month, Day, Year)	March 24, 1993

CORONER USE ONLY

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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	

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

MAR 24 1993

Alexander S. Richards, MD
LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
JUN 30 2 43 PM '93
RECORDER

FILED
JUN 29 1993
Oscar N. Anton
AUDITOR LAKE COUNTY

01561

6.00

SDH 06-004 State Form 10110 (R3 / 3-92) DEATHCER PD 1