R093-1057

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2368-92 93045206 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

Field	Entry
1. DECEASED—NAME (First Middle Last)	Teresa G. Baxter
2. SEX	Female
3a. TIME OF DEATH	05:18P M
3b. DATE OF DEATH (Month Day Year)	November 11, 1992
4. SOCIAL SECURITY NUMBER	494-22-4625
5a. AGE—Last Birthday (Years)	67
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	Nov 14, 1926
7. BIRTHPLACE (City and State or Foreign Country)	Boone County MO
8a. WAS DECEDENT A U S VETERAN?	
8b. YEAR LAST SERVED IN US ARMED FORCES?	
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	1218 Hilltop Ct.
9c. CITY, TOWN, OR LOCATION OF DEATH	Lowell
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Gordon J. Baxter
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	IN
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Lowell
13d. STREET AND NUMBER	1218 Hilltop Ct.
13e. ZIP CODE	46356
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
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) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	Daniel Boatman
19. MOTHER'S NAME (First Middle Maiden Surname)	Bessie Davis

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Gordon J. Baxter
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1218 Hilltop Ct. Lowell, IN 46356
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Nov 13, 1992 Lowell Memorial Park
21c. LOCATION—City or Town, State	Lowell, IN
22a. EMBALMER'S NAME	Kenneth P. Sheets
22b. EMBALMER'S LICENSE NO	FD08900045
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Kenneth P. Sheets (signature)
24b. LICENSE NUMBER (of Licensee)	FD08900045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Sheets Funeral Home, FD83004277, 604 E. Commercial Ave., Lowell, IN

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. Lymphoma
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
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 resulting in the underlying cause given in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)

28a. WAS AN AUTOPSY PERFORMED? no

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED JUL 13 1993

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

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

NOV 13 1992

29b. SIGNATURE AND TITLE OF CERTIFIER — (signature)
29c. MEDICAL LICENSE NO
29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Randall Hile MD, 1020 E. Commercial Ave., Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE — LAKE COUNTY HEALTH COMMISSIONER — (signature) MD
32. DATE FILED (Month, Day, Year) November 13, 1992; 11/12/92

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. 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

4-54-13 Resub Lots 1,2,3,4 BL 3 Trunk Hills Addn to Lowell L.15 W.3 Pt of 14