93050522

INDIANA STATE BOARD OF HEALTH

Local No. 419-91

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Judith A. Ericson
2. SEX: Female
3a. TIME OF DEATH: 8:49 P
3b. DATE OF DEATH (Month, Day, Yr): Feb 17, 1991
4. SOCIAL SECURITY NUMBER: 312-34-3104
5a. AGE—Last Birthday (Years): 55
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): Dec. 5, 1935
7. BIRTHPLACE (City and State or Foreign Country): Gary, IN
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 ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1235 Southwood Dr.
9c. CITY, TOWN OR LOCATION OF DEATH: Lowell
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Married, Never Married, Widowed, Divorced): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John D. Ericson
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: 1235 Southwood Dr.
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? ☒ 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): / College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Albert C. Sidnam
19. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Luck

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John D. Ericson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1235 Southwood Dr. Lowell, IN 46356
20c. Relationship: Spouse

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Feb. 21, 1991 Chapel Lawn Memorial Gardens
LOCATION (City or Town, State): Schererville, 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
24b. LICENSE NUMBER (of Licensee): FD08900045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home 604 Commercial Lowell IN FD83004277

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac arrhythmia — Approximate Interval Between Onset and Death: Unknown

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

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

AUG 03 1993

PART II. Other significant conditions - Conditions contributing to death but not directly related to Part I.

27. WAS DECEDENT PREGNANT WITHIN PAST YEAR? (Yes or no):
28. WAS AUTOPSY PERFORMED? (Yes or no): Yes
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

LAKE COUNTY HEALTH COMMISSIONER

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: Daniel D. Thomas, M.D.
29c. MEDICAL LICENSE NO.: 16120
29d. DATE SIGNED (Month, Day, Year): February 22, 1991

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Daniel D. Thomas, M.D., Coroner 8293 North Wall Street, Crown Point, Indiana 46307
31. HEALTH OFFICER'S SIGNATURE: Alejandro D. Molina, M.D.
32. DATE FILED (Month, Day, Year): FEB 25 9

CORONER USE ONLY

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): February 17, 1991
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian etc.:

FILED
AUG 3 1993

Owner N. Antone

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

00230

KEY 4-59-6 WOODLAND HILLS ADD LOT 6
KEY 6-37-18 S.150 FT OF N. 385 FT OF W. 290 FT S2 SE SW S29 T34 R9 10e