OC 1

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0462-91 93052295 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): ERMA FLECK
2 SEX: FEMALE
3a TIME OF DEATH: 5:17 PM
3b DATE OF DEATH (Month Day Yr): FEBRUARY 24, 1991
4 SOCIAL SECURITY NUMBER: 184-14-0597
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): Jun. 6, 1920
7 BIRTHPLACE (City and State or Foreign Country): Alliance, Ohio
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): THE COMMUNITY HOSPTIAL
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): Thomas Fleck
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b KIND OF BUSINESS/INDUSTRY: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Merrillville
13d STREET AND NUMBER: 5528 Harrison
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): UNK College (1-4 or 5+): UNK

PARENTS

18 FATHER'S NAME (First Middle Last): John Ripley
19 MOTHER'S NAME (First Middle Maiden Surname): Margaret Hudson

INFORMANT

20a INFORMANT'S NAME (Type/Print): Thomas Fleck
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5528 Harrison, Merrillville, Indiana
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 2, 1991 Calumet Park Cemetery
21c LOCATION (City or Town, State): Merrillville, Indiana
22a EMBALMER'S NAME: Raymond White
22b EMBALMER'S LICENSE NO: FDO 8700086
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR:
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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 CEREBRAL ANOXIA	MINUTES
	DUE TO (OR AS A CONSEQUENCE OF): b CARDIAC ARREST	MINUTES
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c MITRAL INSUFFICIENCY	WEEKS
	DUE TO (OR AS A CONSEQUENCE OF): d [illegible] HEART DISEASE	MONTHS

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

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
29b SIGNATURE AND TITLE OF CERTIFIER: HEALTH COMMISSIONER
29c MEDICAL LICENSE NO: 00470
29d DATE SIGNED (Month Day Year): FEBRUARY 25 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): LESTOR DAROS D.O. 3100 45TH ST. HIGHLAND, INDIANA 46322

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32 DATE FILED (Month Day Year): February 28, 1991

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):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian

FILED AUG 10 1993
AUDITOR LAKE COUNTY
00663

STATE OF INDIANA S.S. LAKE COUNTY FILED FOR RECORD AUG 10 PM RECORDER

49-466-30 & 31 Nelson Add Lots 30 & 31, 49-155-9 Glenwood Lot 9 Bl. 2

8/10/93

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