93082189

Local No. 0942-93

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. ....

13 cc's + 2 vet 15

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): RICHARD E. BROWN
2. SEX: Male
3a. TIME OF DEATH: 4:50P M
3b. DATE OF DEATH (Month Day Yr): April 26, 1993
4. SOCIAL SECURITY NUMBER: 310-14-4547
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): MAY 20, 1921
7. BIRTHPLACE (City and State or Foreign Country): HARTWELL, INDIANA
8a. WAS DECEDENT A US VETERAN?: Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): ST MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): RUTH P. MELSON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SUPERVISOR
12b. KIND OF BUSINESS/INDUSTRY: U S STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 2435 WAYNE STREET
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS: ☐ No ☐ Yes
13g. ON A FARM?: X 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ROY A BROWN
19. MOTHER'S NAME (First, Middle, Maiden Surname): FLORA CHAPPELL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JOAN E. HUTCHISON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1624 SERVICE ST., LAKE STATION, IN 46405
20c. Relationship: Daughter

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): APR 30, 1993 EVERGREEN MEMORIAL PARK
21c. LOCATION—City or Town, State: HOBART, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] Stowers
24b. LICENSE NUMBER (of Licensee): FD08900027
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH17300009 REES FUNERAL HOME, BRADY CHAPEL 3781 CENTRAL AV LAKE STATION, IN 46405

THIS IS TO CERTIFY THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE 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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cardiorespiratory arrest	Sec
DUE TO (OR AS A CONSEQUENCE OF): b.	Intracerebral hemorrhage	days
DUE TO (OR AS A CONSEQUENCE OF): c.	Coagulopathy	weeks
DUE TO (OR AS A CONSEQUENCE OF): d.	Abdominal Aortic Aneurysm Repair	days

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

MAY 04 1993

[signature] MD

LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Duodenal ulcer

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no):
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

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: [signature]
29c. MEDICAL LICENSE NO.: 02000328
29d. DATE SIGNED (Month, Day, Year): 5-4-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DENNIS STREETER MD, 119 E. 89TH AVE, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): May 4, 1993

FILED MAY 4 1993

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, etc.

00553

6.00

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

#20-93-47 W "Richard" Bk 13 A

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