93084597

Local No. 4273-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Bessie Dunn
2. SEX: Female
3a. TIME OF DEATH: 8:47A M
3b. DATE OF DEATH (Month, Day, Yr): October 3, 1989
4. SOCIAL SECURITY NUMBER: 306-70-4288
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 5, 1902
7. BIRTHPLACE (City and State or Foreign Country): Hefler, Alabama
8a. WAS DECEDENT A US VETERAN?: No
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): Our Lady of Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): —
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: Her Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 4301 Elm Ave.
13e. ZIP CODE: 46327
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): 3; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): George W. Noles
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Verlan Dunn
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 942 Mohawk Dr. Crown Point, In. 46307
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 6, 1989 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, IN
22a. EMBALMER'S NAME: Marty D. Andersen
22b. EMBALMER'S LICENSE NO.: FD01005205
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Marty D. Andersen
24b. LICENSE NUMBER (of Licensee): FD01005205
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83001253 109 N. East St. Crown Point, IN 46307

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. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Pulmonary edema

DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure ASHD

DUE TO (OR AS A CONSEQUENCE OF): c. [illegible]

DUE TO (OR AS A CONSEQUENCE OF): d.

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

Approximate Interval Between Onset and Death

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

OCT 6 1989

[signature]

LAKE COUNTY HEALTH COMMISSIONER

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): 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. MEDICAL LICENSE NO.: 01026158
29d. DATE SIGNED (Month, Day, Year): 10-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Adela Perez M.D. 2156 Hart St. Dyer, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): Oct 4, 1989

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.

FILED

Dec 15 1993 Armando M. Ortiz 31005

Book 1648 Pg 323-336, Rt. 3.75 A. Rt. 52 SW SW SW SW Kept # 17-29-5 #6, 12/15/93 Jof

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

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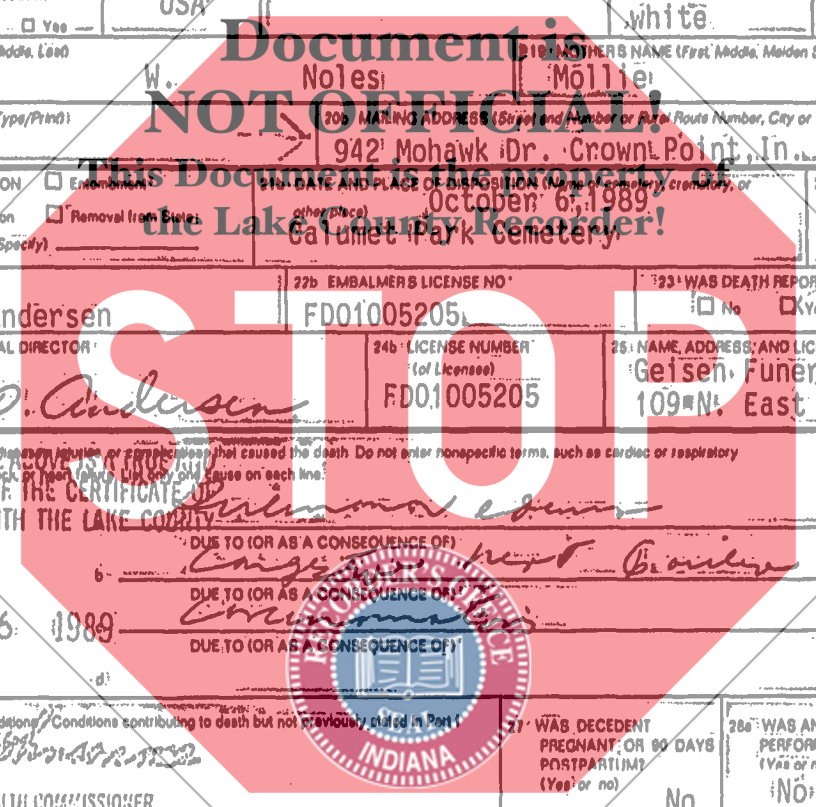
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