94007095

INDIANA STATE DEPARTMENT OF HEALTH

Local No: 26-23-93

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Evelyn L. Taylor

2 SEX: Female

3a TIME OF DEATH: 6:17 A.M.

3b DATE OF DEATH (Month Day Yr): November 8, 1993

4 SOCIAL SECURITY NUMBER: 315-38-8236

5a AGE—Last Birthday (Years): 72

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Minutes):

6 DATE OF BIRTH (Mo Day Yr): Aug. 18, 1921

7 BIRTHPLACE (City and State or Foreign Country): Eagle Creek Township Indiana

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): St. Anthony's Hospital

9c CITY TOWN OR LOCATION OF DEATH: Crown Point

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Clyde Taylor

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Waitress

12b KIND OF BUSINESS/INDUSTRY: Country Club

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Cedar Lake

13d STREET AND NUMBER: 14025 Morse

13e ZIP CODE: 46303

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): 12 College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): William Wennhoff

19 MOTHER'S NAME (First Middle Maiden Surname): Frieda Knuller

INFORMANT

20a INFORMANT'S NAME (Type/Print): Clyde Taylor

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 14025 Morse Cedar Lake, Indiana 46303

20c Relationship: Husband

DISPOSITION

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): November 11, 1993 Chapel Lawn

21c LOCATION—City or Town State: Schererville, Indiana

22a EMBALMER'S NAME: Fred Oparka

22b EMBALMER'S LICENSE NO: FD01016076

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Fred Oparka

24b LICENSE NUMBER (of Licensee): FD01016076

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Ellen Brady FH83000825 Cedar Lake, Indiana

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. end stage emphysema

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

Approximate Interval Between Onset and Death

FILED

DEC 24 1994

Vera N. Anton
AUDITOR LAKE COUNTY

PART II Other significant conditions Conditions contributing to death but not previously stated 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: Jon Mead

29c MEDICAL LICENSE NO: 026009C0

29d DATE SIGNED (Month, Day, Year): 11/11/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 13943 Morse St. Cedar Lake IN 46303

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D.

32 DATE FILED (Month, Day, Year): November 12, 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

25-7-45-1-25-15-48

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCERTIFD

Donald O'Dell P.O. Box 138 Lowell, In 46356