Donald O. Dell
P.O. Box 128
Lowell In. 46356

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0946-92-94007100

State No. ......71......

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): DONALD P. BELEC
2. SEX: MALE
3a. TIME OF DEATH: 3:54 A.M.
3b. DATE OF DEATH (Month Day Yr): APRIL 27, 1992
4. SOCIAL SECURITY NUMBER: 309-22-9864
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MAY 16, 1928
7. BIRTHPLACE (City and State or Foreign Country): WALKERTON, INDIANA
8a. WAS DECEDENT A US VETERAN?: YES, WW II
8b. YEAR LAST SERVED IN US ARMED FORCES?: 1949
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): MAENON SOMESON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): GENERAL FOREMAN
12b. KIND OF BUSINESS/INDUSTRY: US STEEL-GARY WORKS
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 329 S. CALIFORNIA
13e. ZIP CODE: 46342
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+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): JOHN BELEC
19. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE BARDWELL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MAENON BELEC
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 329 S. CALIFORNIA, HOBART, IN. 46342
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 29, 1992 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO.: 1010711
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH 83002380 701 E. 7th STREET, HOBART, IN. 46342

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 arrest
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

THIS CERTIFIES THAT A COMPLETE COPY OF THIS ... ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

JAN 24 1994

APR 28 1992

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: R. R. Barton MD
29c. MEDICAL LICENSE NO.: 17667
29d. DATE SIGNED (Month, Day, Year): 4-27-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): R. R. BARTON, M. D., 6101 MILLER AVENUE, GARY, INDIANA 46403 (938-3274)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): April 28, 1992

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.

00412

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

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