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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0813-93

CERTIFICATE OF DEATH

State No. .....

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)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
ROBERT	J.	McNEES	Male	8:55A M	April 16, 1993

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
319-09-3079	77			JUN 13, 1915	RACINE, WISCONSIN

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.)
Yes	1946	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	LAKE

10 MARITAL STATUS (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
Married	EVELYN E. ELLMAN	PLANT SECURITY	US STEEL GARY WORKS

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HOBART	3808 COLBOURNE STREET

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
46342	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	WHITE	10 /

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN McNEES	MARTHA LOTH

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
EVELYN E. McNEES	3808 COLBOURNE STREET, HOBART, IN 46342	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	APR 22 1993 CALUMET PARK CEMETERY	MERRILLVILLE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
JAMES J. KRAUSE	FD01006463	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, 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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Renal failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Coma & Left Heart Block
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. MAR 11 1994

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
N/A	No	N/A

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Mark Custer	0103645	4/19

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
, 295 S. WISCONSIN ST, HOBART, IN 46342

31. HEALTH OFFICER'S SIGNATURE Alexander S. Tsiliacos, MD

32. DATE FILED (Month, Day, Year) April 19, 1993

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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.
	00734 600

#18-93-2

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