5 CC's

15-357-55

Martin & Martin
1000 E. 80th pl
Suite 521 N.
Merr 46410

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2550-1394020407 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): Ralph L. Jones
2 SEX: Male
3a TIME OF DEATH: 12:45 P.M.
3b DATE OF DEATH (Month Day Yr): October 30, 1993
4 SOCIAL SECURITY NUMBER: 317-14-0251
5a AGE—Last Birthday (Years): 70
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): April 22, 1923
7 BIRTHPLACE (City and State or Foreign Country): Paoli, Indiana
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. 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): Methodist Hospital Southlake Campus
9c CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Mary Louise Rehwinkel
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Production Planning Dept.
12b KIND OF BUSINESS/INDUSTRY: U.S. Steel Corp.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Merrillivlle
13d STREET AND NUMBER: 6988 Van Buren Street
13e ZIP CODE: 46410
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): John William Jones
19 MOTHER'S NAME (First Middle Maiden Surname): Lena Alma Riley

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Louise Jones
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6988 Van Buren St., Merrillville, In. 46410
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): November 3, 1993 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Ronald J. Mesarch
22b EMBALMER'S LICENSE NO.: FD01005912
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Alexis Thomas [signature]
24b LICENSE NUMBER (of Licensee): FD08700735
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410

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	Respiratory failure	2 days
DUE TO (OR AS A CONSEQUENCE OF) b	Severe emphysema	5 years
DUE TO (OR AS A CONSEQUENCE OF) c	Cor pulmonale	5 years
DUE TO (OR AS A CONSEQUENCE OF) d		

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

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

FILED
RECORDER
MAR 14 1994
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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] M.D.
29c MEDICAL LICENSE NO.: 01029166
29d DATE SIGNED (Month Day Year): 11/2/93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Hakam Safadi, M.D., 8315 Virginia, Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month Day Year): November 3, 1993

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.

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JAN 6 1994

SDH06-001 State Form 10110 (R3 / 3-92) DEATHCER PD

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