

ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

94023945

INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 98

CERTIFICATE OF DEATH

State Feb 4, 1994 Date Issued

Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

POSITION

CAUSE OF DEATH

1 DECEASED—NAME (First, Middle, Last) Mary M. Webster		2 SEX Female		3a TIME OF DEATH 11:04 PM		3b DATE OF DEATH (Month, Day, Yr) January 29, 1994	
4 *SOCIAL SECURITY NUMBER 309-09-2139		5a AGE—Last Birthday (Years) 88		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) October 6, 1905		7. BIRTHPLACE (City and State or Foreign Country) CZECHOSLOVAKIA					
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) ST. MARGARET HOSPITAL				9b CITY, TOWN OR LOCATION OF DEATH HAMMOND		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) EUGENE WEBSTER		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOUSEWIFE		12b KIND OF BUSINESS/INDUSTRY OWN HOME	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HAMMOND (P.O. Whiting)		13d STREET AND NUMBER 832 - 114th Street	
13a ZIP CODE 46394		13b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
13c ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian, Black, White, etc. (Specify) WHITE		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (11-4 or 5+) 6			
18 FATHER'S NAME (First, Middle, Last) Paul Gerba				19 MOTHER'S NAME (First, Middle, Maiden Surname) Ann Adam			
20a INFORMANT'S NAME (Type/Print) EUGENE WEBSTER		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip) 832-114th Street, Whiting, IN 46394				20c Relationship HUSBAND	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) 02 February 1994 HOLY CROSS CEMETERY				21c LOCATION (City or Town, State) CALUMET CITY, ILLINOIS	
22a EMBALMER'S NAME THOS. OWENS		22b EMBALMER'S LICENSE NO. FDE 1001049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thos Owens</i>		24b LICENSE NUMBER (of Licensee) FDE 1001049		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS FUNERAL HOME FDH3007291 816-119th St., Whiting, IN 46394			
28. 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. <u>Acute myocardial infarction - lateral wall</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death MAR 25 1994 days <i>Anna N. Antos</i> AUDITOR LAKE COUNTY							
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Stroke with right hemiparesis							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>L. Bernstein</i>				29c MEDICAL LICENSE NO. 27640		29d DATE SIGNED (Month, Day, Year) February 1, 1994	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) L. Bernstein, M. D. 5500 Hohman Avenue, Hammond, Indiana 46320							
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Oremud M.D.</i>						32. DATE FILED (Month, Day, Year) February 4, 1994	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.				01636 <i>1000</i>	

Joseph Shuffler Sr
W. 46th L. 23 Bl. 2
Key # 33-132-30

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This document is the Law of the State of Indiana
STATE OF INDIANA
FILED
MAR 25 1994
AUDITOR LAKE COUNTY