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94029073

Local No. 0587-94

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. .....

Carrie Kaywood
5522 W. 9th Ave
Gary IN 46406

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)
JOHN KAYWOOD	Male	4:17a M	February 28, 1994

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)
430-36-8926	72			July 14, 1921	Earl, Arkansas

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	1945	HOSPITAL ☒ 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
Methodist Hospital Southlake	Merrillville	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	Carrie Hobson	Labor	General

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	5522 West 9th Avenue

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 +)
46406	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	Blk Amer	8	

PARENTS

18 FATHERS NAME (First Middle Last)	19 MOTHERS NAME (First Middle Maiden Surname)
William Kaywood	Josephine Dobby

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
Carrie Kaywood	5522 W. 9th Ave Gary, IN 46406	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
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ____	March 4, 1994 Burr Oak Cemetery	Alsip, Illinois

22a EMBALMER S NAME	22b EMBALMER S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Paul Anthony Robinson	1017284	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Paul Anthony Robinson	1017284	Ennols & Robinson Memorial Chapel 1900 W. 15th Ave Gary, IN 46404

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 Multiple Myloma	
	DUE TO (OR AS A CONSEQUENCE OF)	
	b Bone metastasis	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF)	
	c Congestive heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d I ATTEST THE ABOVE IS A TRUE AND	

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY AUDITOR

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)
No	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
Surendra J. Shah, MD	0103 2180	3/2/94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Surendra J. Shah, MD 53[illegible] Broadway, Suite A Merrillville IN 46410

HEALTH OFFICER

31 HEALTH OFFICER S SIGNATURE Alexander D. Williams MD

32 DATE FILED (Month Day Year) March 16, 1994

CORONER USE ONLY

FILED
APR 8 1994

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
Anna N. Antoxe AUDITOR LAKE COUNTY	L01023

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1