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

James Martin
8217 Clay St.
Merrillville, IN 46410

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. C 701-94 **94030548** State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	AUNIE B. MARTIN
2 SEX	Female
3a TIME OF DEATH	12:01AM
3b DATE OF DEATH (Month Day Yr)	March 21, 1994
4 *SOCIAL SECURITY NUMBER	314-18-3656
5a AGE—Last Birthday (Years)	78
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo. Day, Yr)	JAN 6, 1916
7 BIRTHPLACE (City and State or Foreign Country)	LAUREL, MISSISSIPP
8a WAS DECEDENT A US VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	N/A
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	MILLER'S MERRY MANOR
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)	JAMES Q. MARTIN
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	LABORER PANTS FACTORY
12b KIND OF BUSINESS/INDUSTRY	AUTHUR WIENERS
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN OR LOCATION	MERRILLVILLE
13d STREET AND NUMBER	8217 CLAY STREET
13e ZIP CODE	46410
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	9
College (1-4 or 5+)	

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	JESSIE J. SHUMAKE
19 MOTHER'S NAME (First, Middle, Maiden Surname)	PEARL N. HARRISON

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	NALENA WATERS
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4916 E. 83RD AVE, HOBART, INDIANA 46324
20c Relationship	Daughter

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	MAR 23, 1994 CALUMET PARK CEMETERY
21c LOCATION—City or Town, State	MERRILLVILLE, INDIANA
22a EMBALMER'S NAME	JAMES J. KRAUSE
22b EMBALMER'S LICENSE NO	FDO1006463
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b LICENSE NUMBER (of Licensee)	FDO1006463
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 REES FUNERAL HOME, INC. 600 W. OLD 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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	congestive heart failure	
DUE TO (OR AS A CONSEQUENCE OF) b	atherosclerotic heart disease	
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.

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

Field	Entry
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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	R Billena MD
29c MEDICAL LICENSE NO.	1026067
29d DATE SIGNED (Month Day, Year)	3-23-94
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	R.L. BILLENA JR MD, 5490 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander [illegible] M.D.
32 DATE FILED (Month Day, Year)	March 25, 1994

Field	Entry
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.	

FILED APR 22 1994
Anna M. Anton
RECORDER LAKE COUNTY

1384

Key # 53-5-41-442

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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