

GLV HURTS

94030855

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No: 0865-94

State No:

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED-NAME (First Middle Last) Paul Auburn Davis
2 SEX Male
3a TIME OF DEATH 8:00P
3b DATE OF DEATH (Month Day Yr) April 10, 1994
4 SOCIAL SECURITY NUMBER 514-10-2795
5a AGE--Last Birthday (Years) 76
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day, Yr) June 8, 1917
7 BIRTHPLACE (City and State or Foreign Country) Forgan, Oklahoma
8a WAS DECEDENT A US VETERAN? Yes
8b YEAR LAST SERVED IN US ARMED FORCES? 1945
9a PLACE OF DEATH (Check only one See instructions)
HOSPITAL [X] Inpatient [] ER/Outpatient [] DOA
OTHER [] Nursing Home [] Other (Specify) [] Residence

DECEDENT

9b FACILITY NAME (If not institution give street and number) Southlake Methodist
9c CITY TOWN OR LOCATION OF DEATH Merriiiville
9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married
11 SURVIVING SPOUSE (If wife give maiden name) Hilda Thompson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work; none during most of working life Do not use retired) Pipe Liner
12b KIND OF BUSINESS/INDUSTRY Oil

PARENTS

13a RESIDENCE--STATE Indiana
13b COUNTY Lake
13c CITY TOWN OR LOCATION Griffith
13d STREET AND NUMBER 311 N. Rensselaer
13e ZIP CODE 46319
13f INSIDE CITY LIMITS [] No [X] Yes
13g ON A FARM? [X] No [] Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [] Yes
16 RACE--American Indian Black White etc (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (10-12) 8
College (1-4 or 5+) 3

INFORMANT

18 FATHER'S NAME (First Middle Last) James Lewis
19 MOTHER'S NAME (First Middle Maiden Surname) Sarah Ann Cross
20a INFORMANT'S NAME (Type/Print) Hilda Davis
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 N. Rensselaer Griffith, In 46319
20c Relationship Wife

DISPOSITION

21a METHOD OF DISPOSITION [] Entombment [X] Burial [] Cremation [] Removal from State [] Donation [] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 14, 1994 Chapel Lawn Memorial Gardens
21c LOCATION--City or Town, State Schererville, Indiana

CAUSE OF DEATH

22a EMBALMER'S NAME Leonard Gregorczyk
22b EMBALMER'S LICENSE NO FD08800305
23 WAS DEATH REPORTED TO CORONER? [X] No [] Yes
24a SIGNATURE OF FUNERAL DIRECTOR
24b LICENSE NUMBER (of Licensee) FD01006015
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME B3002754 Fagen-Miller Funeral Gardens, INC 242 N. Griffith Blvd. Griffith, In 46319

26 PART I: IMMEDIATE CAUSE (Final disease or condition resulting in death) CARCINOMA OF PROSTATE WITH BONE METASTASIS
DUE TO (OR AS A CONSEQUENCE OF)
CONDITIONS, if any, which gave rise to the immediate cause stating the underlying cause last:
12 1994 DUE TO (OR AS A CONSEQUENCE OF)
DUE TO (OR AS A CONSEQUENCE OF)

CERTIFIER

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) APR 25 1994
28a. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No
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 Barbara
29c. MEDICAL LICENSE NO. 01030107
29d. DATE SIGNED (Month, Day, Year) 4-12-94

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) B. A. Gural M.D 125 East 89th Ave Merriiiville In 46410
31. HEALTH OFFICER'S SIGNATURE Alexander B. Williams, M.D.
32. DATE FILED (Month, Day, Year) April 12, 1994

33. MANNER OF DEATH [] Natural [] Pending Investigation [] Accident [] Suicide [] 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

KEY 26-118-29 OAK FOREST APP. LOTS 29, 30 & 31 BLOCK C



FILED

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