

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
INDIANA STATE DEPARTMENT OF HEALTH

Local No. **94031806** State No.
94 APR 27 AM 20 16 DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER I.C. 16-1-12-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT:

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) Dorothy G. Ashley		2 SEX female	3a TIME OF DEATH 12:29a	3b DATE OF DEATH (Month Day, Yr) December 26, 1993	
4 SOCIAL SECURITY NUMBER 309-16-8616	5a AGE—Last Birthday (Years) 87	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) Feb. 21, 1906	
7 BIRTHPLACE (City and State or Foreign Country) Shoals, Indiana	8a WAS DECEDENT A US VETERAN? no	8b YEAR LAST SERVED IN US ARMED FORCES? none	9a PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Residence:		
9b FACILITY NAME (If not institution give street and number) Med-Inn		9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ernest Ashley	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired!) Homemaker	12b KIND OF BUSINESS/INDUSTRY Own Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 401 1/2 Cameron Avenue		
13a ZIP CODE 46327	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (11-4 or 5 +)		18 FATHER'S NAME (First Middle Last) Walter Franklin			
19 MOTHER'S NAME (First Middle Maiden Surname) Cora Williams		20a INFORMANT'S NAME (Type/Print) Mrs. Doris Pilarczyk			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Briar Lane, Munster, IN 46321		20c Relationship Niece			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) December 29, 1993 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Schererville, Indiana	
22a EMBALMER'S NAME John C. Ault		22b EMBALMER'S LICENSE NO. FD01013507		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FD01013507		25 NAME, ADDRESS, AND PHONE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 704 1/2 Kennedy Avenue Hammond, IN 46321	
26 PART I: Enter the disease, 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) Terminal Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE STARTING THE UNDERLYING CAUSE LAST Significant Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death	
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	
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>[Signature]</i>			29c MEDICAL LICENSE NO. IN 20248	29d DATE SIGNED (Month, Day, Year) 12/27/93	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) W. V. HEHMAN, JR., P. O. BOX 100, HAMMETT AVE, MUNSTER, IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) December 28, 1993	
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:
34a 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.			

#36-152-27

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ALEXTON LAKE COUNTY