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*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

Local No. 0606-94

CERTIFICATE OF DEATH

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) MAXINE A. LEWIS		2 SEX Female	3a TIME OF DEATH 9:45P	3b DATE OF DEATH (Month, Day, Yr) March 8, 1994	
4 *SOCIAL SECURITY NUMBER 311-32-0834		5a AGE—Last Birthday (Years) 58	5b UNDER 1 YEAR Months: Days	5c UNDER 1 DAY Hours: Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) SEP 30, 1935		7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA			
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER		9c CITY, TOWN OR LOCATION OF DEATH: HOBART	9d COUNTY OF DEATH: LAKE		
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) WILLIAM B. LEWIS		12a DECEDENT'S USUAL OCCUPATION (Give kind of work. Do not use retired) HOMEMAKER	12b KIND OF BUSINESS/INDUSTRY: HOME	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HOBART	13d STREET AND NUMBER 1234 W. 38TH AVENUE		
13e ZIP CODE 46342	13f 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.)	16 RACE—American Indian, Black, White, etc. (Specify) WHITE	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12		17.1 Elementary/Secondary (0-12) 12 17.2 College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) FREDRICK W. JOHNSON		19 MOTHER'S NAME (First, Middle, Maiden Surname) MARY HELEN MOSIER			
20a INFORMANT'S NAME (Type/Print) WILLIAM B. LEWIS		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 W. 38TH AVE, HOBART, INDIANA 46342	20c Relationship Husband		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) MAR 10 1994 RIDGELAWN CEMETERY		21c LOCATION—City or Town, State GARY, IN	
22a EMBALMER'S NAME JAMES J. KRAUSE		22b EMBALMER'S LICENSE NO. FDO1006463	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b LICENSE NUMBER (of Licensee) FDO1006463	24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME (of Licensee) REES FUNERAL HOME, INC 600 W. OLD RIDGE RD., HOBART, IN 46342		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) Respiratory Arrest		a. DUE TO (OR AS A CONSEQUENCE OF) Metastatic Large Cell Carcinoma		b. DUE TO (OR AS A CONSEQUENCE OF) 6 months	
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last		c. DUE TO (OR AS A CONSEQUENCE OF) MAR 7 1994		d. DUE TO (OR AS A CONSEQUENCE OF)	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Hypertension, Generalized Osteoarthritis					
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>Jeffery Smith M.D.</i>		29c MEDICAL LICENSE NO. 01030268	29d DATE SIGNED (Month, Day, Year) 3/10/94		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) JEFFERY SMITH MD, 1400 S. LAKE PARK AVENUE, HOBART, INDIANA					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams M.D.</i>				32 DATE FILED (Month, Day, Year) March 14, 1994	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) MAR 7 1994	34b PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) APR 28 1994	34c DESCRIBE HOW INJURY OCCURRED APR 28 1994	
34d LOCATION (Street and Number or Rural Route Number, City or Town, State)		34e DATE PRONOUNCED DEAD (Month, Day, Year)			
34f MOTOR VEHICLE ACCIDENT? (Yes or no) NO		34g DATE FILED (Month, Day, Year) 01808			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Key # 17-100-25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 28 1994

Alexander M. Anton AUDITOR LAKE COUNTY