

Rees Funeral Home
7600 W. Ridge Rd, Hobart 46342

INDIANA STATE DEPARTMENT OF HEALTH

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8062

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

Local No. 3079-94

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

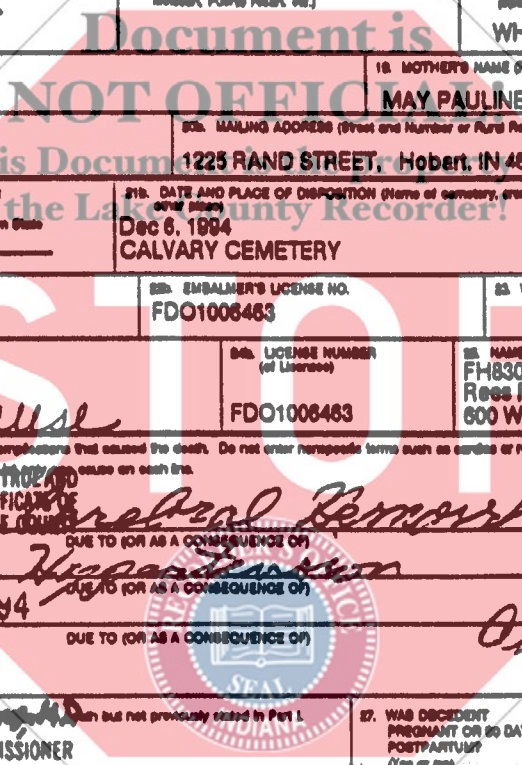
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED NAME (Print Middle Last) WILLIAM JOSEPH DAVIS		2. SEX Male	3a. TIME OF DEATH 10:31PM	3b. DATE OF DEATH (Month Day Yr) December 2, 1994
4. SOCIAL SECURITY NUMBER 317-20-7850	5a. AGE - Last Birthday (Years) 67	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jan 28, 1927
7. BIRTHPLACE (City and State or Foreign Country) SPARTA, TN	8. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> ERO/Outpatient <input type="checkbox"/> OCA <input type="checkbox"/> Residence			
9a. WAS DECEDENT A U.S. VETERAN? Yes	9b. YEAR LAST SERVED IN U.S. ARMED FORCES 1948	9c. CITY TOWN OR LOCATION OF DEATH Hobart		
10. FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER		10b. COUNTY OF DEATH Lake		
11. MARITAL STATUS (Specify) Married	11a. SURVIVING SPOUSE (If wife, give maiden name) JEAN M. DIEDERICH	11b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) OWNER	11c. KIND OF BUSINESS INDUSTRY DAVIS PETROLEUM, INC.	
12a. RESIDENCE - STATE IN	12b. COUNTY Lake	12c. CITY TOWN OR LOCATION Hobart	12d. STREET AND NUMBER 1225 RAND STREET	
13a. ZIP CODE 46342	13b. 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 you 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 (8-12) 12		18. DATE OF DEATH (Month Day Year) DEC 2 1994		
19. FATHER'S NAME (Print Middle Last) WILLIAM EARL DAVIS		19. MOTHER'S NAME (Print Middle, Modern Surname) MAY PAULINE KNOWLES		
20a. INFORMANT'S NAME (Type/Print) JEAN M. DAVIS		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 RAND STREET, Hobart, IN 46342		20c. Relationship Wife
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) Dec 6, 1994 CALVARY CEMETERY		21c. LOCATION - City or Town, State PORTAGE, IN
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FDO1006463		22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
23a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		23b. LICENSE NUMBER (of Licensee) FDO1006463		23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342
24. PART I. Enter the disease, injury or complication that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest. Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day				
25. IMMEDIATE CAUSE OF DEATH (List on one line) Myocardial Infarction HEALTH DEPT. FILE WITH THE LAKE COUNTY HEALTH DEPT. DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) Myocardial Infarction DEC 5 1994 DEC 7 1994 <i>James J. Krause</i>				
26. PART II. Other conditions contributing to death but not previously coded in Part I. LAKE COUNTY HEALTH COMMISSIONER		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28. WAS AN AUTOPSY PERFORMED? (Yes or no) No
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No				
30a. 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.		30b. SIGNATURE AND TITLE OF CERTIFIER <i>John O. Carter MD</i>		
30c. MEDICAL LICENSE NO. 01017634		30d. DATE SIGNED (Month Day Year) 12-5-94		
31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) JOHN O. CARTER MD, 285 SOUTH WISCONSIN, HOBART, IN 46342				
32. HEALTH OFFICER'S SIGNATURE <i>Alvan S. Williams, MD</i>				32. DATE FILED (Month Day Year) December 5, 1994
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		33a. DATE OF INJURY (Month Day Year)	33b. TIME OF INJURY	33c. INJURY AT WORK? (Yes or no)
33d. DESCRIBE HOW INJURY OCCURRED		34. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		
34. LOCATION (Street and Number or Rural Route Number City or Town State)				
35a. DATE PRONOUNCED DEAD (Month Day Year)		35b. MOTOR VEHICLE ACCIDENT? (Yes or no) If you specify driver, passenger, pedestrian, etc. 000421		

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Key # 18-247-3

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 94 DEC - 7 PM 2:25 AM RECORDED OFFICE