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47 N. Delions St
Hobart 46342
John Easton Jr.

20 Reg
2 Vet
22 Total

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 2223-93 | State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	JOHN S. EASTON SR.
2. Sex	Male
3a. Time of Death	3:15A M
3b. Date of Death (Month, Day, Yr.)	September 7, 1993
4. Social Security Number	314-22-6563
5a. Age—Last Birthday (Years)	66
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo. Day, Yr)	JUL 22, 1927
7. Birthplace (City and State or Foreign Country)	DETROIT, MICHIGAN
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces?	1946
9a. Place of Death (Check only one. See instructions)	Hospital: XX Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☐ 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 (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	CATHERINE L. RUWERSMA
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	BRICKLAYER
12b. Kind of Business/Industry	BRICKLAYERS LOCA
13a. Residence—State	INDIANA
13b. County	PORTER
13c. City, Town or Location	VALPARAISO
13d. Street and Number	785 W. 50 N.
13e. Zip Code	46383
13f. Inside City Limits	XX No ☐ Yes
13g. On a Farm?	XX No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	WHITE
17. Decedent's Education (Specify only highest grade completed)	Elementary/Secondary (0-12): 11; College (1-4 or 5+):

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	JOHN ALFRED EASTON
19. Mother's Name (First, Middle, Maiden Surname)	MYRTLE E. JONES

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	CATHERINE L. EASTON
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	785 W. 50 N., VALPARAISO, INDIANA 46383
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	SEP 10, 1993 GRACELAND CEMETERY
21c. Location—City or Town, State	VALPARAISO, INDIANA
22a. Embalmer's Name	JAMES J. KRAUSE
22b. Embalmer's License No.	FDO1006463
23. Was Death Reported to Coroner?	XX 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 46

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Mesothelioma

DUE TO (OR AS A CONSEQUENCE OF): b.

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

Field	Entry
27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	N/A
28a. Was an Autopsy Performed? (Yes or no)	Yes
28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)	

CERTIFIER

29a. Certifier (Check only one)

XX 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	[signature]
29c. Medical License No.	01027933
29d. Date Signed (Month, Day, Year)	9-13-93
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	SHREYAS A. DESAI MD, 2640 HAMSTROM RD, PORTAGE, IN 46368

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	[signature], M.D.
32. Date Filed (Month, Day, Year)	September 17, 1993

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.	

#17-15-14

SEP 17 1993

FILED DEC 16 1994

Dean N. Antos, Auditor Lake County

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD SAMUEL ORLICH RECORDER

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State Form 10110 (R3 / 3-92)

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