20cc

Auslen-Good
5201 Foundation Ste A
C.P. 46307

93-0714

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. .... State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	ARNOLD ESKILSON
2. SEX	MALE
3a. TIME OF DEATH	3:30 AM
3b. DATE OF DEATH (Month Day Yr)	SEPTEMBER 13, 1993
4. SOCIAL SECURITY NUMBER	329-07-1357
5a. AGE—Last Birthday (Years)	82
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	JULY 19, 1911
7. BIRTHPLACE (City and State or Foreign Country)	BEECHER, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	NONE
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ 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	GARY
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	MILDRED CHRISTENSEN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	OWNER
12b. KIND OF BUSINESS/INDUSTRY	DIXIE DAIRY COMPANY
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	GARY
13d. STREET AND NUMBER	8711 LAKESHORE DRIVE
13e. ZIP CODE	46403
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

PARENTS

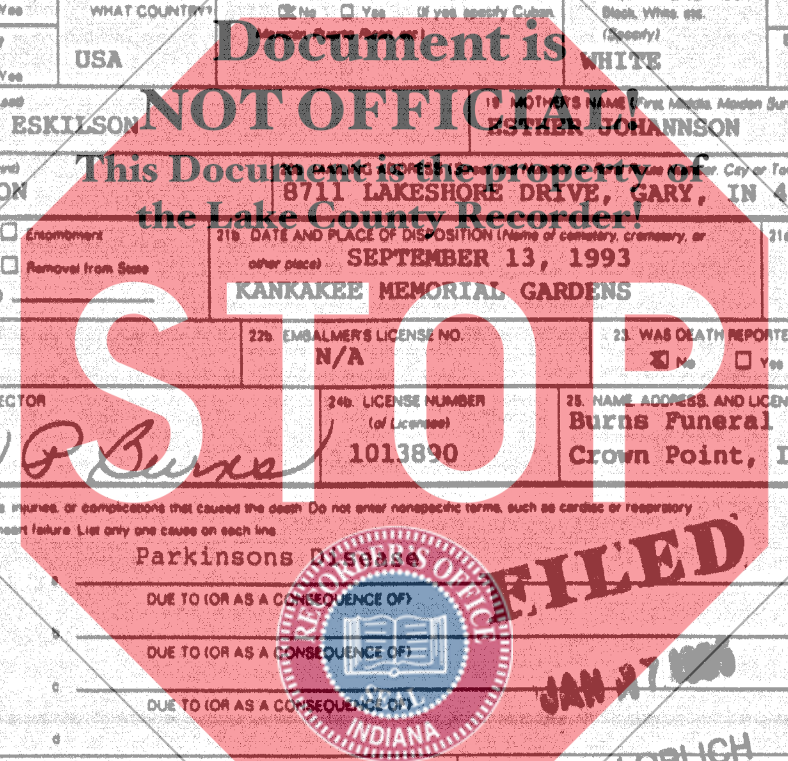
Field	Entry
18. FATHER'S NAME (First, Middle, Last)	MIELS C. BJERG ESKILSON
19. MOTHER'S NAME (First, Middle, Maiden Surname)	ESTHER JOHANNSON

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MILDRED ESKILSON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8711 LAKESHORE DRIVE, GARY, IN 46403
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	SEPTEMBER 13, 1993 KANKAKEE MEMORIAL GARDENS
21c. LOCATION—City or Town, State	KANKAKEE ILLINOIS
22a. EMBALMER'S NAME	N/A
22b. EMBALMER'S LICENSE NO.	N/A
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Terrence P Burns
24b. LICENSE NUMBER (of Licensee)	1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002485



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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Parkinsons Disease	years
b.	DUE TO (OR AS A CONSEQUENCE OF)	
c.	DUE TO (OR AS A CONSEQUENCE OF)	
d.	DUE TO (OR AS A CONSEQUENCE OF)	

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)	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)	N/A

FILED JAN 27 1998

SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 98 JAN 27 PM 1:44 AMASA G. COLE CHIEF DEP RECORDER

CERTIFIER

29a. CERTIFIER (Check only one)

☒ 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	Michael M Ramsey MD
29c. MEDICAL LICENSE NO.	Illinois 036-042599
29d. DATE SIGNED (Month Day Year)	9-14-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Michael Ramsey, 1725 W. Harrison, Chicago, IL 60612

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month Day Year)	SEP. 2 1 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.	

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CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE SEP 21 1909