Rees Funeral Home Inc
600 Ridge Rd
Hobart, IN 46342

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PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): DOLORES M. SHIMEL
2 SEX: FEMALE
3a TIME OF DEATH: 12:30 P
3b DATE OF DEATH (Month Day Yr): JANUARY 10, 1995
4 SOCIAL SECURITY NUMBER: 315-14-8065
5a AGE—Last Birthday (Years): 72
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): OCTOBER 16, 1922
7 BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
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): PORTER MEMORIAL HOSPITAL
9c CITY, TOWN OR LOCATION OF DEATH: VALPARAISO
9d COUNTY OF DEATH: PORTER
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): ALBERT C. SHIMEL, SR.
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SECRETARY
12b KIND OF BUSINESS/INDUSTRY: LAKE STATION SCHOOLS
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: LAKE STATION
13d STREET AND NUMBER: 2274 TIPPECANOE STREET
13e ZIP CODE: 46405
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): HARRY LAMBERT
19 MOTHER'S NAME (First, Middle, Maiden Surname): BERNICE LEWIS

INFORMANT

20a INFORMANT'S NAME (Type/Print): ALBERT C. SHIMEL, SR.
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2274 TIPPECANOE ST., LAKE STATION, IN 46405
20c Relationship: HUSBAND

DISPOSITION

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): JANUARY 13, 1995 CALVARY CEMETERY
21c LOCATION—City or Town, State: PORTAGE, INDIANA
22a EMBALMER'S NAME: JAMES J. KRAUSE
22b EMBALMER'S LICENSE NO.: FDO 1006463
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: David C. Mayer
24b LICENSE NUMBER (of Licensee): FDO 1012048
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83005613 REES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN 46368

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	Congestive Heart Failure	6 weeks
DUE TO (OR AS A CONSEQUENCE OF) b	Extensive Anterior wall MI, c aneurysm dilitation	6 weeks
DUE TO (OR AS A CONSEQUENCE OF) c	Arteriosclerotic Heart Disease + Total occlusion LAD	6 weeks
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:

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

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
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 20707
29d DATE SIGNED (Month Day Year): 1/13/95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN A. FORCHETTI, M.D. 502 WALL STREET VALPARAISO, IN 46383

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Gary A. Babcock MD
32 DATE FILED (Month Day Year): January 13, 1995

FILED

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):

JAN 23 1995
SAM ORLICH
AUDITOR LAKE COUNTY

000966

AMASA G. COLB CHIEF DEP. RECORDER
95003867

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

E. Gary Real Est Co's 1st Add Lots 4,5,6, N½ of 7,9,10 All Block 1 Key#19-30-4,5,6,7,9,10 un.#14

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№ 827221

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

HEALTH OFFICER

STOP