Key# 36-252-17
Turner Meyn Park
L 17 BL 5

"ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal."

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 42 State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-8

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Betty D. Canady
2. SEX: Female
3a. TIME OF DEATH: 12:05 AM
3b. DATE OF DEATH (Month Day Yr): January 31, 1994
4. SOCIAL SECURITY NUMBER: 306-01-7095
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): MAY 2, 1918
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a. WAS DECEDENT A US 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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife give maiden name): Andrew Canady
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 2837 Cleveland St.
13e. ZIP CODE: 46323
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): 11 College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): John Malarik
19. MOTHER'S NAME (First Middle Maiden Surname): Suzanna Paul

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Andrew Canady
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2837 Cleveland St., Hammond, IN 46323
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB 3, 1994 Concordia Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Charles D. Scheuer Jr.
22b. EMBALMER'S LICENSE NO: 1006049
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Charles D. Scheuer, Jr. [signature]
24b. LICENSE NUMBER (of Licensee): 1006049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323

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
a.	Acute gastrointestinal bleeding	4 days
b. DUE TO (OR AS A CONSEQUENCE OF)	[illegible]	20 yrs.
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

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): NA

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: Fred Adler M.D. [signature]
29c. MEDICAL LICENSE NO.: 01019251
29d. DATE SIGNED (Month Day Year): 2/1/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Fred Adler M.D., 800 MacArthur Blvd., Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICERS SIGNATURE: Dr. Timothy Raykovich [signature]
32. DATE FILED (Month Day Year): 2-4-94

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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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