1 10 cc

49-468-17478

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

Local No. 95-0416

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-8

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): WAVEL ALEXANDER
2. SEX: Female
3a. TIME OF DEATH: 4:45 P.M.
3b. DATE OF DEATH (Month, Day, Yr.): May 25, 1995
4. SOCIAL SECURITY NUMBER: 316-24-5999
5a. AGE—Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): August 12, 1909
7. BIRTHPLACE (City and State or Foreign Country): Lawrenceville, Illnois
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None
9. 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): Gary Methodist Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widow
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2433 Calhoun
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): unknown Thompson
19. MOTHER'S NAME (First, Middle, Maiden Surname): unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Alfred Russell Alexander
20b. MAILING ADDRESS (Street and Number or P.O. Box, City or Town, State, Zip Code): 1744 Wabash ct. Dolton, Il 60419
20c. RELATIONSHIP: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 30, 1995 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: George J. Johnson
22b. EMBALMER'S LICENSE NO.: FDE 8900006
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Charles J. Schuerman
24b. LICENSE NUMBER (of Licensee): 1006049
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, In. 46323 FD 002869

STATE OF INDIANA LAKE COUNTY RECORD FILED FOR RECORD MAY 26 1995 AT 2:14 PM RECORDER

CAUSE OF DEATH

26. PART I. Enter the disease, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardio Pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Shock
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.

27. WAS DECEDENT PREGNANT OR IN 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

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: Murray Stasick MD
29c. MEDICAL LICENSE NO.: 16030 B
29d. DATE SIGNED (Month, Day, Year): June 1, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Murray Stasick, M.D., 7330 Indianapolis Blvd., Hammond, Indiana 46324

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE SIGNED (Month, Day, Year): JUN 02 1995

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. HOW INJURY OCCURRED
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY Ooccurred
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or R.F.D. 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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