John Hovanec, 2606 Central Ave., Lake Station 46405

10 cc's T+2 Ve

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

Local No. 0161-94

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
RONALD	M.	COX	Male	5:45A	January 13, 1994

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
315-05-3669	77			DEC 24, 1916	ROCKVILLE, INDIANA

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1945	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	BETTY J. COX	SHIPPING FOREMAN	SUNBEAM ELECTRIC

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	GARY	1021 WYOMING STREET

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46403	[ ] No [ ] Yes	[X] No [ ] Yes	USA	[ ] No [ ] Yes	WHITE	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
OTHA COX	IDA NOLEN

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
BETTY J. COX	1021 WYOMING ST., GARY, INDIANA 46403	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	JAN 17, 1994 CALVARY CREMATORY	PORTAGE, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES J. KRAUSE	FD01006463	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Kenneth R. Stevens ASSISTANT	FD08900027	FH19300009 REES FUNERAL HOME, BRADY CHAPEL 3781 CENTRAL AV LAKE STATION, IN 46440

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. Cardiopulmonary failure	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): b. Bilateral pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF): c. Renal failure	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

JAN 18 1994 — Alexander S. Williams, M.D. — INDIANA STATE HEALTH COMMISSIONER

FILED SEP-5 1995 — AUG 31 1995 — SAM ORLICH CLERK LAKE COUNTY

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF DEATH? (Yes or no)
NO	No	

CERTIFIER

29a. CERTIFIER (Check only one)

[X] 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
RR Barton MD	17667 Ind	1-19-94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
RR BARTON MD, 6101 MILLER AVENUE, GARY, IN 46403

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S. Williams M.D.	January 17, 1994

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	001994

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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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1