Helen Sloan
2533 Birch St.
Whiting, In.
46394

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

Local No. 95-260

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 95055360

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): WILLIAM R. SLOAN
2. SEX: MALE
3a. TIME OF DEATH: 6:51 PM
3b. DATE OF DEATH (Month, Day, Yr.): September 7, 1995
4. *SOCIAL SECURITY NUMBER: 314-26-6060
5a. AGE—Last Birthday (Years): 66
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): August 2, 1929
7. BIRTHPLACE (City and State or Foreign Country): WEST VIRGINIA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1947
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
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): Helen Powell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Cab Driver
12b. KIND OF BUSINESS/INDUSTRY: CALUMET CAB
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HAMMOND (P.O. Whiting)
13d. STREET AND NUMBER: 2533 Birch Avenue
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): JOHN A. SLOAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): ALBERTA WARD

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Helen Sloan
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2533 Birch Ave. Whiting, IN 46394
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 11, 1995 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, INDIANA
22a. EMBALMER'S NAME: THOS. OWENS
22b. EMBALMER'S LICENSE NO.: FDE 1001049
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thos. Owens
24b. LICENSE NUMBER (of Licensee): FDE 1001049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: OWENS FUNERAL HOME FDH 3007291 816 - 119th St. Whiting, IN 46394

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
Conditions if any which gave rise to the immediate cause stating the underlying cause last: b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: DIABETES MELLITUS OBSTRUCTIVE LUNG DISEASE

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

#34-330-5

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: 0102 7418
29d. DATE SIGNED (Month, Day, Year): 9/11/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. GEORGE ASTERIS 2450 - 165th St. HOMMOND, IN 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): 9-11-95

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 Ooccurred:
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.

001139