* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 2084-95

# INDIANA STATE DEPARTMENT OF HEALTH

## 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) |
|---|---|---|---|
| Shirley A. Carey | Female | 6:22P.M. | September 14, 1995 |

| 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) |
|---|---|---|---|---|---|
| 352-16-1105 | 70 | | | APR 26, 1925 | Joliet, IL |

| 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) |
|---|---|---|
| No | N/A | HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify) |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| St. Anthony Medical Center | Crown Point | 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 | Willard Carey | Homemaker | at Home |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Crown Point | 904 E. Crestview Ct. |

| 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+) |
|---|---|---|---|---|---|---|---|
| 46307 | [ ] No [X] Yes | [X] No [ ] Yes | USA | [X] No [ ] Yes | White | 12 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Walter Harrington | Vernice Wilde |

**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 |
|---|---|---|
| Willard Carey | 904 E. Crestview Ct. Crown Point, IN. 46307 | Husband |

**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 [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State | SEP 19, 1995 Calumet Park Cemetery | Merrillville, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Marty Andersen | FD01005205 | [ ] No [ ] Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| [signature] | FD09000013 | FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307 |

**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. | CARDIAC ARREST - Atherosclerotic heart disease | 3 hours |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. b. DUE TO (OR AS A CONSEQUENCE OF) | Congestive heart failure | |
| c. DUE TO (OR AS A CONSEQUENCE OF) | Diabetes mellitus | |
| d. DUE TO (OR AS A CONSEQUENCE OF) | | |

| 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 CAUSE OF DEATH? (Yes or no) |
|---|---|---|---|
| Chronic renal insufficiency; Old cerebrovascular accidents | 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) |
|---|---|---|
| [signature] /Attending Cardiologist | 01043788 B | 9-18-95 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Boris Sheralovsky, M.D. Cardiac Care Ass., 297 W. Franciscan Lane, Crown Point, IN 4630

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month, Day, Year) |
|---|---|
| [signature] | September 19, 1995 |

| 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) |
|---|---|
| | |

| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | 34h. MOTOR VEHICLE (If yes, specify driver, passenger, pedestrian, etc.) |
|---|---|
| | |

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

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder!
STOP
THE UNDERSIGNED CERTIFIES THE ABOVE TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ... HEALTH OFFICER SEP 19 1995 ... LAKE COUNTY HEALTH COMMISSIONER
9508093
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 OCT -2 AM 11:15 ... RECORDER
FILED OCT 2 1995 SAM ORLICH AUDITOR LAKE COUNTY
000118
9.00