* 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. 2206-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 46410

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)
DORIS L. CALAWAY	Female	4:40 P. M	September 26, 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)
305-32-5182	64			April 3, 1931	Oblong, Illinois

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	------	HOSPITAL: ☐ 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
Town Centre Health Care Center	Merrillville	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	Searl S. Calaway	Homemaker	At Home

13a. Residence—State	13b. County	13c. City, Town, or Location	13d. Street and Number
Indiana	Lake	Merrillville	5920 Arthur 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+)
46410	☐ No ☒ Yes	☐ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12	

PARENTS

18. Father's Name (First, Middle, Last)	19. Mother's Name (First, Middle, Maiden Surname)
Jacob A. Cooley	Ruth I. Hornbrook

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
Searl S. Calaway	5920 Arthur St. Merrillville, In. 46410	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
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)	September 29, 1995 Calumet Park Cemetery	Merrillville, Indiana

22a. Embalmer's Name	22b. Embalmer's License No.	23. Was Death Reported to Coroner?
Alexis Thanos	FD08600505	☒ No ☐ Yes

24a. Signature of Funeral Director	24b. License Number (of Licensee)	25. Name, Address, and License Number of Funeral Home
Robert A. Craig Jr.	FD08700735	Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410

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. SEPTICEMIA
DUE TO (OR AS A CONSEQUENCE OF):
b. MULTIPLE DECUBITI
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions. Conditions contributing to death but not previously listed in Part I: ALZHEIMER'S DISEASE

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)
No	No	No

FILED NOV 1 1995

SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 NOV -1 AM 10:01

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	29c. Medical License No.	29d. Date Signed (Month, Day, Year)
Mona K. Stern MD	01018886	9 29 95

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Dr. Mona K. Stern, 7250 Arthur Blvd., Merrillville, Indiana 46410

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month, Day, Year)
Alexander S. Williams, M.D.	October 2, 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 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