

* 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.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Jones
5920 Arthur
State No. *Merrillville, Ind. 46410*

Local No. *2206-95*

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS
INFORMANT

DISPOSITION

CAUSE OF DEATH

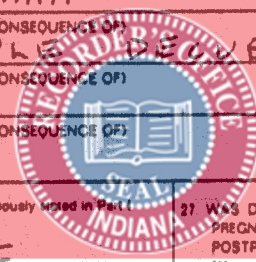
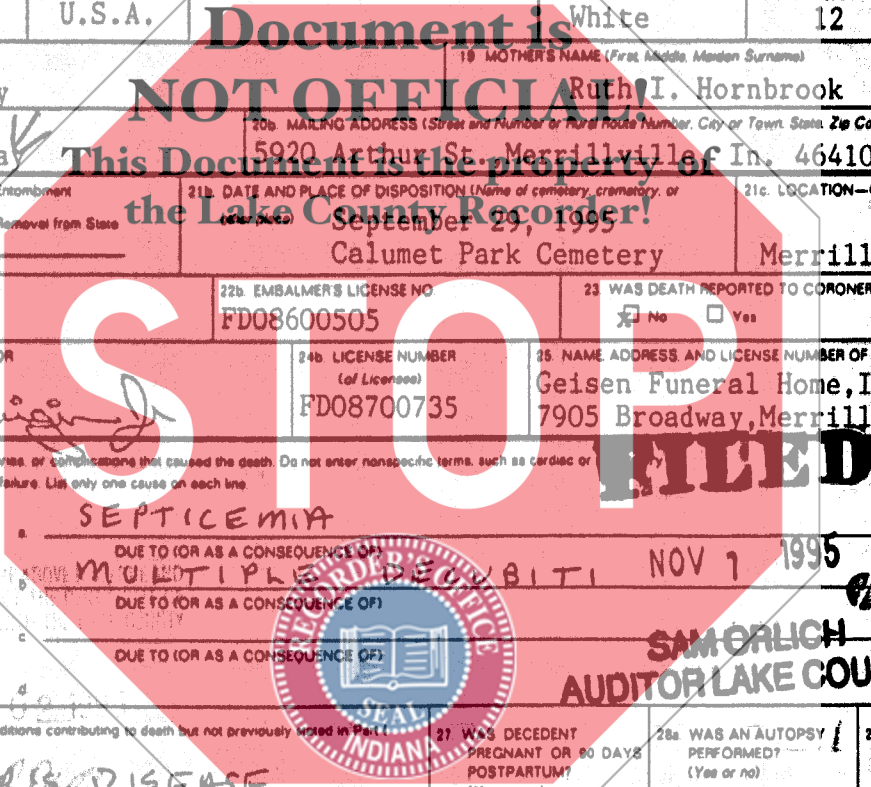
CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) DORIS L. CALAWAY		2 SEX Female		3a TIME OF DEATH 4:40 P. M.		3b DATE OF DEATH (Month, Day, Year) September 26, 1995	
4 SOCIAL SECURITY NUMBER 305-32-5182		5a AGE—Last Birthday (Year) 64		5b UNDER 1 YEAR Months: _____ Days: _____		5c UNDER 1 DAY Hours: _____ Minutes: _____	
6 DATE OF BIRTH (Mo, Day, Yr) April 3, 1931		7 BIRTHPLACE (City and State or Foreign Country) Oblong, Illinois					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----		8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Residence			
9a FACILITY NAME (If not mentioned, give street and number) Town Centre Health Care Center				9b CITY, TOWN OR LOCATION OF DEATH Merrillville		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Searl S. Calaway		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY At Home	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Merrillville		13d STREET AND NUMBER 5920 Arthur Street	
13e ZIP CODE 46410		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
13g ON A FARM? <input type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian, Black, White, etc. White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) Jacob A. Cooley				19 MOTHER'S NAME (First, Middle, Maiden Surname) Ruth I. Hornbrook			
20a INFORMANT'S NAME (Type/Print) Searl S. Calaway				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5920 Arthur St. Merrillville, Ind. 46410		20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 29, 1995 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Alexis Thanos				22b EMBALMER'S LICENSE NO. FD08600505		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig</i>				24b LICENSE NUMBER (of Licensee) FD08700735		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH8307762 7905 Broadway, Merrillville, Ind. 46410	
26 PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac arrest, check, or heart failure. List only one cause on each line. SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF) MULTIPLE DECBUTI NOV 7 1995 DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____ Approximate Interval Between Onset and Death							
26 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) 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) No							
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Mona K. Stern MD</i>				29c MEDICAL LICENSE NO. 01018886		29d DATE SIGNED (Month, Day, Year) 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							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams MD</i>						32 DATE FILED (Month, Day, Year) October 2, 1995	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
		34d. 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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STATE OF INDIANA
LAKE COUNTY

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