Local No. 5918-93

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): PRESTON RAY TAYLOR
2 SEX: MALE
3a TIME OF DEATH: 3:45 P M
3b DATE OF DEATH (Month Day Yr): DECEMBER 22, 1993
4 SOCIAL SECURITY NUMBER: 283-09-6729
5a AGE—Last Birthday (Years): 78
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day Yr): APRIL 22, 1915
7 BIRTHPLACE (City and State or Foreign Country): LEXINGTON, ILLINOIS
8a WAS DECEDENT A U.S. VETERAN?: YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 1110 HIGHWAY 330
9c CITY, TOWN OR LOCATION OF DEATH: GRIFFITH
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): WIDOWED
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): HEATER
12b KIND OF BUSINESS/INDUSTRY: FORGING
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: GRIFFITH
13d STREET AND NUMBER: 1110 HIGHWAY 330
13e ZIP CODE: 46319
13f INSIDE CITY LIMITS: ☒ No ☐ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): PRESTON RAY TAYLOR
19 MOTHER'S NAME (First Middle Maiden Surname): BERTHA PEARL McMAHAN

INFORMANT

20a INFORMANT'S NAME (Type/Print): SHIRLEY HALL
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1110 HIGHWAY 330, GRIFFITH, INDIANA 46319
20c Relationship: DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 29, 1993 CHAPEL LAWN MEMORIAL GARDENS
21c LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a EMBALMER'S NAME: LAWRENCE MILLER
22b EMBALMER'S LICENSE NO.: FD01006015
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD01006015
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL GARDENS INC 242 N. GRIFFITH BLVD. GRIFFITH, IN FH83002754

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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. Carcinoma of lung
DUE TO (OR AS A CONSEQUENCE OF): b. Chronic obstructive lung disease
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Pleural effusion
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):

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: Charles D. Egnatz MD
29c MEDICAL LICENSE NO.: 19054
29d DATE SIGNED (Month, Day, Year): 12-27-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): C.D. Egnatz, M.D. 1326 W. U.S. Rt. 30 Schererville, IN 46375

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32 DATE FILED (Month, Day, Year): Dec 27, 1993

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 OCCURRED:
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 (Mo/Day/Yr):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

FILED NOV 1 1995 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 NOV -2 PM 2:57 MARGARET... RECORDER

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