Burke, murphy
Catanzaro Cuppy
8585 B'way
Merr. 46410

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

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Local No. 0271-94 State No. 7

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 H. McColley
2. SEX: Male
3a. TIME OF DEATH: 11:12A
3b. DATE OF DEATH (Month Day Yr): April 25, 1994
4. SOCIAL SECURITY NUMBER: 315-14-8054
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day Yr): OCT 6, 1926
7. BIRTHPLACE (City and State or Foreign Country): Crown Point, IN
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): 8454 Morse Place
9c. CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mary Ann Surovic
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Crane Operator
12b. KIND OF BUSINESS/INDUSTRY: LTV Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 8454 Morse Place
13e. ZIP CODE: 46307
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): 9; College (1-4 or 5+):

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): Joseph McColley
19. MOTHER'S NAME (First, Middle, Maiden Surname): Bernice Lamphier

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Mary Ann McColley
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8454 Morse Place, Crown Point, IN 46307
20c. Relationship: Wife

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APR 28, 1994 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN
22a. EMBALMER'S NAME: Larry A. Geisen
22b. EMBALMER'S LICENSE NO.: FD09000013
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01000328
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN 46307

**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): DILATED CARDIOMYOPATHY — Approximate Interval Between Onset and Death: 2 yrs

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

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.

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

**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: [signature]
29c. MEDICAL LICENSE NO.: 27841
29d. DATE SIGNED (Month, Day, Year): 4/26/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Trent Orfanos M.D., 297 Franciscan Drive, Crown Point, IN 46307

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): April 27, 1994

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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 (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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


THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
JUN 1 1994

FILED FOR RECORD
96 FEB 13 9:20
STATE OF INDIANA LAKE COUNTY
RECORDED

FEB 13 1996
SAM ORLICH
AUDITOR LAKE COUNTY

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