"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. 1069-94 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): Norma J. Dunn
2. SEX: female
3a. TIME OF DEATH: M
3b. DATE OF DEATH (Month Day Yr): May 7, 1994
4. *SOCIAL SECURITY NUMBER: 233-46-7683
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): September 25, 1931
7. BIRTHPLACE (City and State or Foreign Country): Scranton Pennsylvan
8a. WAS DECEDENT A U.S. VETERAN?: no
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: n/a
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Lowell Health Care Center
9c. CITY, TOWN OR LOCATION OF DEATH: Lowell
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): married
11. SURVIVING SPOUSE (If wife give maiden name): Floyd Dunn
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: PO Box 546
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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Harvey Kerns
19. MOTHER'S NAME (First Middle Maiden Surname): Laura Hawkins

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Floyd Dunn
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 546 Crown Point, Indiana 46307
20c. Relationship: Husband

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): May 10, 1994 Oakland Memory Lane
21c. LOCATION—City or Town, State: ~~Dalton~~ DOLTON, Illinois
22a. EMBALMER'S NAME: none
22b. EMBALMER'S LICENSE NO.: n/a
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01014511
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Roa Highland, Indiana 56422 FH83007500

FILED FEB 16 1996

SAM ORLICH AUDITOR LAKE COUNTY

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. Coronary Artery Disease — years
DUE TO (OR AS A CONSEQUENCE OF)
b. Insulin Dependent Diabetes — years
DUE TO (OR AS A CONSEQUENCE OF)
c. Chronic Obstructive Pulmonary Disease — years
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: Morbid Obesity

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): n/a

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] - Physician
29c. MEDICAL LICENSE NO.: 0200002
29d. DATE SIGNED (Month Day Year): 5-9-94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Richard Kessler 3068 Lucas Parkway Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander B. Williams, M.D.
32. DATE FILED (Month, Day, Year): May 9, 1994

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 (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF A CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FEB 15 1996

Alexander B. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

96 010165

LAKE COUNTY FILED FOR RECORD MAR 96 ... RECORDER

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

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