* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AN COMPLETE COPY OF DEATH ON FILE WITH TH HAMMOND HEALTH DEPARTMENT.

Local No. 178

MAR 15 1996 — Date Issued — Franklin D. Fernandez — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-8

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED–NAME (First Middle Last): John P Davey
2. SEX: Male
3a. TIME OF DEATH: 9:27AM
3b. DATE OF DEATH (Month Day Yr): February 28, 1996
4. SOCIAL SECURITY NUMBER: 320-22-0498
5a. AGE - Last Birthday (Years): 68
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): Jan 12, 1928
7. BIRTHPLACE (City and State or Foreign Country): Blue Island, IL
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1947
8c. 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): 3003 East 165 th.Street
9c. CITY TOWN OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Frances Johnson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Plumber
12b. KIND OF BUSINESS/INDUSTRY: Maintanance
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 3003 East 165 th.Street
13e. ZIP CODE: 46323
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): 08; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): James Davey
19. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Sheehan

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Frances Davey
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3003 - 165-TH Street, Hammond, IN 46323
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Other (Specify) ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Feb 29, 1996 Calumet Park Cemetery
21c. LOCATION - City or Town State: Merrillville, Indiana
22a. EMBALMER'S NAME: James W. Gholston
22b. EMBALMER'S LICENSE NO.: 1004194
22. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee):
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

CAUSE OF DEATH

26. PART I — Enter the disease injuries or complications that caused the death. Do not enter terminal events 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):
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Myocardial Infarction Arteriosclerotic Heart 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

Approximate Interval Between Onset and Death:

PART II. Other significant conditions — Conditions contributing to death but not previously listed in Part I:
Myocardial Arteriosclerosis
Cerebrovascular Accident

27. WAS DECEDENT PREGNANT OR IN 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: John Lehman M.D.
29c. MEDICAL LICENSE NO: 18203
29d. DATE SIGNED (Month Day Year): February 2 / 27 / 96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): John Lehman M.D., 716 Sebastian Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Fernandez M.D.
32. DATE FILED (Month Day Year): February 29, 1996

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): 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.: No

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Tom Davey
7303 Pleasant Rd.
Waterford, WI 53185

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 SEP 23 PM 2:53 MARGARET BELL CLEVELAND RECORDER

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SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

9.00 CS JP