* 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.

Local No. 2767-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

C488214 LD

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	DOROTHY S SWENSON
2 SEX	FEMALE
3a TIME OF DEATH	5:11 AM
3b DATE OF DEATH (Month Day Yr)	NOV.25,1995
4 *SOCIAL SECURITY NUMBER	311 62 3207
5a AGE—Last Birthday (Years)	84
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	DEC.24,1910
7 BIRTHPLACE (City and State or Foreign Country)	EAST CHICAGO, IN
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)	ST. ANTHONY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH	CROWN POINT
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	WIDOW
11 SURVIVING SPOUSE (If wife give maiden name)	NONE
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	415 E. 72nd Ave.
13e ZIP CODE	46410
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) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	HARRY STUART
19 MOTHER'S NAME (First Middle Maiden Surname)	FLORENCE KELLER

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	STUART SWENSON
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	118 PARK MANOR DR., DYER, IN 46311
20c Relationship	SON

DISPOSITION

Field	Entry
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)	NOVEMBER 28,1995 CHAPEL LAWN MEMORIAL GARDENS
21c LOCATION—City or Town, State	SCHERERVILLE INDIANA
22a EMBALMER'S NAME	GORDON L. JONES
22b EMBALMER'S LICENSE NO	1010711
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Terrence P. Burns
24b LICENSE NUMBER (of Licensee)	1013890
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FD8300245

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): END STAGE ISCHEMIC CARDIOMYOPATHY

DUE TO (OR AS A CONSEQUENCE OF): ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE

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 resulting in the underlying cause given in Part I.

Field	Entry
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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	27841
29d DATE SIGNED (Month, Day, Year)	11/28/95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. TRENT ORFANOS, 290 Franciscan Dr., Crown Point, IN 769-8560

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, MD
32 DATE FILED (Month, Day, Year)	November 30, 1995

Field	Entry
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.	

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

Stamps: Chicago Title Insurance Company; 96062754; FILED SEP 17 1996; STATE OF INDIANA LAKE COUNTY FILED FOR RECORD SEP 17 PM 1:15 MARGARET (?) RECORDER; RAISED SEAL; RECORDER'S OFFICE SEAL INDIANA; THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY...