Local No. 1576-88

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)			2 SEX	3 DATE OF DEATH (Month Day Year)
PAUL		CASHMAN	MALE	JULY 9, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR (Months / Days)	5c UNDER 1 DAY (Hours / Minutes)	6 DATE OF BIRTH (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
304-12-1756	70			SEPT. 16, 1917	HAMMOND, INDIANA

8 YEAR LAST SERVED IN US ARMED FORCES? NEVER

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)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
1357 MADISON AVE.	DYER	LAKE

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	MAGDELINE YOKOVICH	SUPERINTENDANT	CHEMICAL CO.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	DYER	1357 MADISON AVE.

13e INSIDE CITY LIMITS? (Yes or No)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.)	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed)	
			Specify		Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46311	XXX	WHITE		2

PARENTS

17 FATHER'S NAME (First, Middle, Last): FREDERICK JOSEPH CASHMAN

18 MOTHER'S NAME (First, Middle, Maiden Surname): MARIE FRANCES JAMES

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
MAGDELINE CASHMAN	1357 MADISON AVE. DYER, IND. 46311	WIFE

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	20b DATE AND PLACE OF DISPOSITION (Cemetery, Crematory, or other place)	20c LOCATION—City or Town, State
	JULY 13, 1988 ETYWOOD CEMETERY	HAMMOND, IND.

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Edward Miller	FDE1007176	FAGEN-MILLER FUNERAL GARDENS, INC. DYER, INDIANA 46311 FDH3001504

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a To the best of my knowledge death occurred at the time, date and place stated. Signature and Title	23b LICENSE NUMBER (ILL)	23c DATE SIGNED (Month Day Year)
< Moormeier, MD	036-075074	7/29/88

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month Day Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No)
7:10 P.M.	JULY 9, 1988	YES

SEE INSTRUCTIONS

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardiorespiratory arrest	Immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF) Metastatic adenocarcinoma of the colon	3 yrs.
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I

CAUSE PERTINENT TO DEATH

28a WAS AN AUTOPSY PERFORMED? (Yes or No) NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

SEE INSTRUCTIONS

29a CERTIFIER (Check only one)

☑ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge death occurred due to the cause(s) and manner as stated

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated

CERTIFIER

Alexander B. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER (ILLINOIS)	29d DATE SIGNED (Month Day Year)
Gil Moormeier	036-075074	7/28/88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Gil Moormeier University of Chicago Medical Center 5841 So. Maryland Ave, Box 420 Chicago, IL 60637

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE

32 DATE SIGNED (Month Day Year) 7/29/88

CORONER OR MEDICAL EXAMINER USE ONLY

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)

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CERTIFIED COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

SEP 26 1996

LAKE COUNTY FILED FOR RECORD 96 SEP 26 PM 2:46 MARGARET BYNUM RECORDER

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14-63-22

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