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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2934-93 — **CERTIFICATE OF DEATH** — 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)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
RUTH	HOPE	ARNOLD	FEMALE	12:10 P.M.	DECEMBER 22, 1993

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 (Mo. Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
307-40-6252	76			March 4, 1917	Hammond, Ind.

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	None	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10 MARITAL STATUS (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
Single	None	Teacher	Public Schools

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Ind.	Lake	Highland	8806 Woodward Ave.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46322	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	No	White	12	4

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Stephen A. Arnold	Grace L. Arnold

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Fern Arnold	8806 Woodward Ave, Highland, Ind. 46322	Sister

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town State
☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	Dec. 24, 1993 Northwest, Ind. Cremation Services	Crown Point, Ind. 46307

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
None		☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1013612	McCoy Funeral Chapel 5713 Hohman Ave. Hammond, Ind. 46320

CAUSE OF DEATH

28 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)	ACUTE CONGESTIVE HEART FAILURE	HOURS
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) HYPERTENSION	DAYS
	DUE TO (OR AS A CONSEQUENCE OF) HYPERCELESTEMIA	WEEKS
	DUE TO (OR AS A CONSEQUENCE OF) PROTEIN CALORIE MALNUTRITION	30 1996 WEEKS

JAN 26 1994

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

	27 WAS DECEDENT PREGNANT POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
CARCINOMA MYELOMA - WEEKS	NO	AUTOPSY PERFORMED BY LAKE COUNTY CORONER	

CERTIFIER

27-50-9

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
[signature]	01161	DECEMBER 22, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print)
DR. CLAUDE A. FOREIT, D. O. 3831 HOHMAN AVENUE HAMMOND, INDIANA 46327

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander D. Williams, M.D.	December 27, 1993

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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 (R3 / 3-92) DEATHCER/PD 1