

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0811-96

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

| | | | | |
|--|---|---|---|---|
| 1 DECEASED—NAME (First Middle Last) Juanita L. Reed | | 2 SEX Female | 3a TIME OF DEATH 4:05 P. | 3b DATE OF DEATH (Month Day Year) April 20, 1996 |
| 4 SOCIAL SECURITY NUMBER 318-26-4935 | 5a AGE—Last Birthday (Years) 64 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Month Day Year) Oct. 2, 1931 |
| 7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois | 8a WAS DECEDENT A U.S. VETERAN? No | | | |
| 8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A | | 8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | |
| 9a FACILITY NAME (If not included give street and number) St Margaret Mercy Hospital South | | 9b CITY/TOWN OR LOCATION OF DEATH Dyer | 9c COUNTY OF DEATH Lake | |
| 10 MARITAL STATUS Married | 11 SURVIVING SPOUSE PHILIP R. Reed | 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 Own Home |
| 13a RESIDENCE—STATE Indiana | 13b COUNTY Lake | 13c CITY/TOWN OR LOCATION Dyer | 13d STREET AND NUMBER 1449 Madison Ave | |
| 13e ZIP CODE 46311 | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14 CITIZEN OF WHAT COUNTRY? USA | 15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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) 12 | | 18 FATHER'S NAME (First Middle Last) Walter H. Peterson | | |
| 19 MOTHER'S NAME (First Middle Maiden Surname) Alice L. LaCourse | | 20a INFORMANT'S NAME (Type/Print) Philip R. Reed | | |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1449 Madison Ave Dyer, Indiana 46311 | | 20c Relationship Husband | | |
| 21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) April 24, 1996 Calumet Park Cemetery | | 21c LOCATION—City or Town, State Merrillville, Indiana |
| 22a EMBALMER'S NAME Edward F. Mullaney | | 22b EMBALMER'S LICENSE NO. FDO 1007176 | 23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i> | | 24b LICENSE NUMBER (of Licensee) FDO 1007176 | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes, Inc 1920 Hart St Dyer, Indiana 46311 | |
| 26 PART I: Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest. Please print in block letters. Do not abbreviate. Each line COMPLETE COPY OF THE CERTIFICATE OF DEATH Cardiovascular vascular accident IMMEDIATE CAUSE (DISEASE, INJURY, OR COMPLICATION resulting in death) HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause stating the underlying cause last FEB OR 1997 DUE TO (OR AS A CONSEQUENCE OF) PART II: Other significant conditions or conditions contributing to death but not previously stated in Part I Diabetes mellitus | | | | |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No | | 28 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No | | 29 DATE SIGNED (Month Day Year) April 22, 1996 |
| 29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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) as stated | | 29b SIGNATURE AND TITLE OF CERTIFIER <i>Alexander B. Williams D.O.</i> AUDITOR LAKE COUNTY | | |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Gerard M. Davidson, D.O. 840 Richard Road, Dyer, IN 46311 | | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>Alexander B. Williams M.D.</i> | | | | 32 DATE FILED (Month Day Year) April 22 1996 |
| 33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. | | 000327 | | |

#14-161-25

970077
STATE OF INDIANA
LAKE COUNTY
FILED
FEB 7 1997
MERRILLVILLE
RECORDS & CLERK