* 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. 0315-97

43689

INDIANA STATE DEPARTMENT OF HEALTH

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): EDWARD SCOTT
2 SEX: MALE
3a TIME OF DEATH: 12:14 PM
3b DATE OF DEATH (Month Day Yr): FEBRUARY 9, 1997
4 *SOCIAL SECURITY NUMBER: 354-12-5903
5a AGE—Last Birthday (Years): 70
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): Feb.14, 1926
7 BIRTHPLACE (City and State or Foreign Country): St. Louis,MO
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): THE COMMUNITY HOSPITAL
9c CITY, TOWN OR LOCATION OF DEATH: MUNSTER
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Frances Lundswall
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Welder
12b KIND OF BUSINESS/INDUSTRY: Construction
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2637 Fairbanks
13e ZIP CODE: 46406
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 11; College (1-4 or 5+): -

PARENTS

18 FATHER'S NAME (First Middle Last): Arthur Lee Scott
19 MOTHER'S NAME (First Middle Maiden Surname): Helen Dickerson

INFORMANT

20a INFORMANT'S NAME (Type/Print): Frances Scott
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2637 Fairbanks Gary,IN 46406
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 12,1997 Oakland Memory Lanes
21c LOCATION—City or Town, State: Dolton,IL
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO: 1045964
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 8601763
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3002819 5840 Hohman Hammond,IN 46320

970009591

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): a. Acute Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Cardiovascular 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.

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Old Stroke, Diabetes Mellitus, Insulin Dependent, Abdominal Aortic Aneurysm

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): No

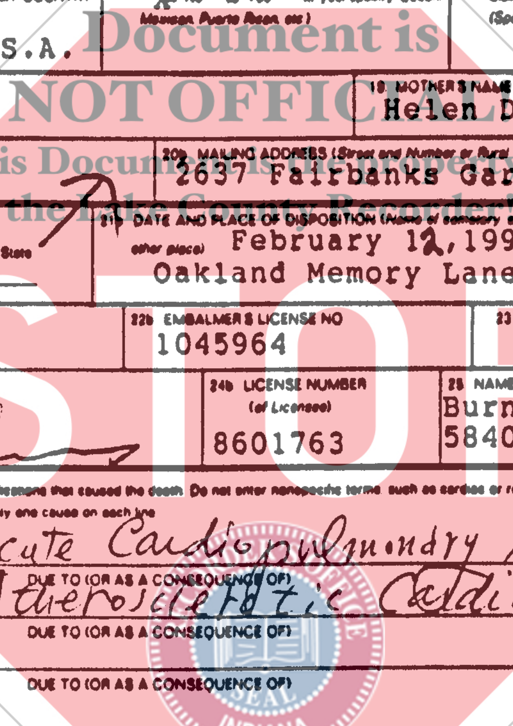
CERTIFIER

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: [signature] M.D.
29c MEDICAL LICENSE NO: 01035185
29d DATE SIGNED (Month Day Year): 2-10-97
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): OH J. LEE, M.D. 800 STATE LINE AVENUE CALUMET CITY, ILLINOIS 60409

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month Day Year): February 11 1997

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)
34g DATE PRONOUNCED DEAD (Month Day Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.



FILED
FEB 14 1997
SAM ORLICH
AUDITOR LAKE COUNTY
000709

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
97 FEB 14 AM 11:
MORRIS W. CARTER RECORDER

Garden Acres Lot 34 Block 1
Key# 49-152-34
Un# 41

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