

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
INDIANA STATE BOARD OF HEALTH
97 FEB 24 12:57
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

AUG 17 1988

Franklin D. Remuda M.D.
Hammond Health Commissioner

Local No. **970.F.285.**

MOBIS W. CARTER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

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

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

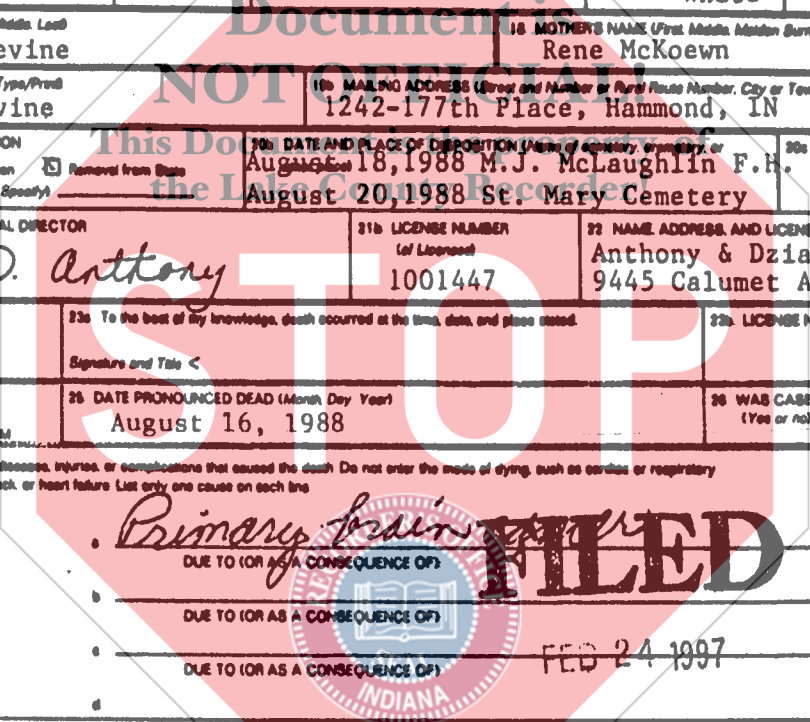
CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1 DECEASED—NAME FIRST MIDDLE LAST Richard F. RECORDED Devine, Sr.		2 SEX Male	3 DATE OF DEATH (Month Day Year) August 16, 1988
4 SOCIAL SECURITY NUMBER 177-05-9095A	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days Hours Minutes	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Month Day Year) March 4, 1917	7 BIRTHPLACE (City and State or Foreign Country) Philadelphia, PA		
8 YEAR LAST SERVED IN US ARMED FORCES? No	9a PLACE OF DEATH (Check only one (See instructions)) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) St. Margaret Hospital		9c CITY, TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake
10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Rita Shotwell	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life (Do not use retired)) V.P. Executive Director	12b KIND OF BUSINESS/INDUSTRY Lake Area United Way
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 1242-177th Place
13e INSIDE CITY LIMITS? (Yes or no) Yes	13f FARM No	13g ZIP CODE 46324	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify
15 RACE—American Indian, Black, White, etc. (Specify) White	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 2		
17 FATHER'S NAME (First Middle Last) Hugh P. Devine		18 MOTHER'S NAME (First Middle Maiden Surname) Rene McKeown	
19a INFORMANT'S NAME (Type/Print) Rita E. Devine		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1242-177th Place, Hammond, IN 46324	19c Relationship Wife
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 18, 1988 M.J. McLaughlin F.H. Wilkes-Barre, PA August 20, 1988 St. Mary Cemetery Wilkes-Barre, PA	20c LOCATION—City or Town, State Wilkes-Barre, PA
21a SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		21b LICENSE NUMBER (of Licensee) 1001447	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz F.H.—3002916 9445 Calumet Ave., Munster, IN 46321
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <		23b LICENSE NUMBER	23c DATE SIGNED (Month Day Year)
24 TIME OF DEATH 4:55 a.		25 DATE PRONOUNCED DEAD (Month Day Year) August 16, 1988	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No
27 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Primary brain cancer</i> DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Approximate Interval Between Onset and Death <i>months</i>			
27 PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <i>Sepsis</i>			
28a CERTIFIER (Check only one) <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.		28b WAS AN AUTOPSY PERFORMED? No	28c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29a SIGNATURE AND TITLE OF CERTIFIER <i>Thomas D. Brubaker M.D.</i>		29b LICENSE NUMBER 01024438	29c DATE SIGNED (Month Day Year) Aug 17, 1988
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27 (Type/Print) T. Brubaker, M.D. 110 Ridge Road, Munster, Indiana 46321			
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>		32 DATE FILED (Month Day Year) AUG 17 1988	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY
34c PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34d INJURY AT WORK? (Yes or no)	34e DESCRIBE HOW INJURY OCCURRED 001091 900 St
35 LOCATION (Street (and Number or Rural Route Number, City or Town, State)		36 LOCATION (Street (and Number or Rural Route Number, City or Town, State)	

Key # 310-32-234-27



FEB 24 1997

SBH08-004 State Form 10110 Rev. 10/87 DEATH/POI
→ Tim Kelly 9250 Columbia Ave St. 2A Munster 46341 Cc#1427