

\* ATTENTION ESTATE: Disclosure of the SS# is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

C 490045 <sup>locca</sup>  
CO

Local No. 0271-96

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

1. DECEASED-NAME (First Middle Last) <b>LOIS ARMES</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>6:17AM</b>	3b. DATE OF DEATH (Month Day Yr) <b>January 25, 1996</b>
4. SOCIAL SECURITY NUMBER <b>308-56-1452</b>	5a. AGE - Last Birthday (Years) <b>51</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) <b>Jan 6, 1945</b>
6a. WAS DECEDENT A U.S. VETERAN? <b>No</b>	6b. YEAR LAST SERVED IN U.S. ARMED FORCES <b>N/A</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>BRICEVILLE, TN</b>		
8a. PLACE OF DEATH (Check only one - See instructions)		8b. CITY TOWN OR LOCATION OF DEATH <b>Merrillville</b>		
8c. COUNTY OF DEATH <b>Lake</b>		8d. HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> EROutpatient <input type="checkbox"/> DOA		
8e. OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		8f. Residence <input type="checkbox"/>		
9a. FACILITY NAME (If not institution, give street and number) <b>BROADWAY METHODIST SOUTHLAKE</b>		9b. CITY TOWN OR LOCATION OF DEATH <b>Merrillville</b>		
9c. COUNTY OF DEATH <b>Lake</b>		9d. FACILITY TYPE (Specify)		
10. MARITAL STATUS (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS INDUSTRY <b>HOME</b>
13a. RESIDENCE - STATE <b>IN</b>	13b. COUNTY <b>Lake</b>	13c. CITY TOWN OR LOCATION <b>Lake Station</b>	13d. STREET AND NUMBER <b>3214 MINNESOTA STREET</b>	
13e. ZIP CODE <b>46405</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian, Black, White, etc. (Specify) <b>WHITE</b>
17. DECEASED'S EDUCATION (Specify only highest grade completed)		18. DECEASED'S EDUCATION (Specify only highest grade completed)		
Elementary/Secondary (0-12)		College (1-4 or 5+)		
19. FATHER'S NAME (First, Middle, Last) <b>VESTER PATTEN</b>		20. MOTHER'S NAME (First, Middle, Maiden Surname) <b>OSIE JONES</b>		
21a. INFORMANT'S NAME (Type/Print) <b>JAMES ARMES</b>		21b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>157 LESLIE WAY, Chesterton, IN 46304</b>		21c. Relationship <b>Son</b>
22a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)		22b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Jan 27, 1996 GRACELAND CEMETERY</b>		22c. LOCATION - City or Town State <b>Valparaiso, IN</b>
23a. EMBALMER'S NAME <b>JAMES J. KRAUSE</b>		23b. EMBALMER'S LICENSE NO. <b>FDO1006463</b>		23c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO1006463</b>	24c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342</b>	
25. PART II. Cause of Death (Enter the disease, 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.)				
IMMEDIATE CAUSE (The disease or condition resulting in death) <b>29 1996</b>				
a. <b>Carcinoma of Lung. Recurrent</b>				
b. <b>Extensive metastasis</b>				
c. <b>...</b>				
d. <b>...</b>				
26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>COPD</b>				
27. WAS DECEDENT PREGNANT OR 90 DAYS 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)
<b>No</b>		<b>No</b>		<b>No</b>
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.		29b. 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.		
29c. 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.		29d. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Williams, MD</i>		
29e. MEDICAL LICENSE NO. <b>01035695</b>		29f. DATE SIGNED (Month Day Year) <b>1-29-96</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>J.P. SANGHVI MD, 8127 MERRILLVILLE ROAD, MERRILLVILLE, IN 46410</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Joseph Williams, MD</i>				32. DATE FILED (Month Day Year) <b>January 29, 1996</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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. <b>00112</b>		34i. SIGNATURE <i>Joseph Williams</i>		

Key 35-50-40-18-27  
Part 1: see 23-36-8  
Part 2: see 23-36-8

NOT OFFICIAL  
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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
RECORDED  
JAN 29 1996  
PH 1:24  
MORRIS W. CARTER

FILED  
FEB 20 1997  
SAM ORLICH  
AUDITOR LAKE COUNTY