[redacted]

• 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. 190

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

MAR 7, 1997 — Date Issued — Hammond Health Commissioner

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): Mary Louisa Crose
2 SEX: Female
3a TIME OF DEATH: 3:52 AM
3b DATE OF DEATH (Month Day Yr): March 5, 1997
4 *SOCIAL SECURITY NUMBER: 725-14-2593
5a AGE—Last Birthday (Years): 78
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): April 5, 1918
7 BIRTHPLACE (City and State or Foreign Country): Perrysville, IN
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: None
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): St. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Jay D. Crose
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: Hammond
13d STREET AND NUMBER: 6717 Ridgeland Ave
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS: ☐ No XX Yes
13g ON A FARM?: XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: XX 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): 8; College (1-4 or 5+): -----

PARENTS

18 FATHER'S NAME (First Middle Last): Purl John Rusk
19 MOTHER'S NAME (First Middle Maiden Surname): May Rachel Flawhearty

INFORMANT

20a INFORMANT'S NAME (Type/Print): Jay D. Crose
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6717 Ridgeland Ave, Hammond, IN
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 7, 1997 Spring Hill Cemetery
21c LOCATION—City or Town, State: Danville, IL
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO: 1045964
23 WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish FH 5840 Hohman Ave Hammond, IN #3002819 For Barrick & Sons FH Danville, IL Signature Only

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrythmia
DUE TO (OR AS A CONSEQUENCE OF)
b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Partial bowel obstruction
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death

FILED APR 02 1997
SAM ORLICH AUDITOR LAKE COUNTY

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Generalized arteriosclerotic Heart & Vascular disease; Post bowel resection
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): N.A.

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: A Willardo, MD
29c MEDICAL LICENSE NO: IN 1020554
29d DATE SIGNED (Month Day Year): 2-5-97 (march)
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. A. Willardo, M.D. 7150 Indianapolis Blvd Hammond, IN

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin J. Yamamoto, M.D.
32 DATE FILED (Month Day Year): MAR 07 1997

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

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

CS 9.00