* 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. 3535-96 State No. ....

41520

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): Raymond William McQuiston
2 SEX: Male
3a TIME OF DEATH: 8:15 P.M.
3b DATE OF DEATH (Month Day Yr): December 24, 1996
4 SOCIAL SECURITY NUMBER: 303-36-4493
5a AGE—Last Birthday (Years): 79
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo. Day Yr): September 13, 1917
7 BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 9115 Kennedy Avenue
9c CITY, TOWN OR LOCATION OF DEATH: Highland
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Lena Papendick
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Self-Employed
12b KIND OF BUSINESS/INDUSTRY: Poultry and Egg
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Highland
13d STREET AND NUMBER: 9115 Kennedy
13e ZIP CODE: 46322
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): 10; College (1-4 or 5+):

97020963

PARENTS

18 FATHER'S NAME (First Middle Last): William McQuiston
19 MOTHER'S NAME (First Middle Maiden Surname): Wilkelmina Ulrich

INFORMANT

20a INFORMANT'S NAME (Type/Print): Lena McQuiston
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9115 Kennedy Ave; Highland, IN 46322
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): December 28, 1996 Ridgelawn Cemetery
21c LOCATION—City or Town, State: Gary, Indiana
22a EMBALMER'S NAME: Lawrence Miller
22b EMBALMER'S LICENSE NO: FD01006015
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Lawrence Miller
24b LICENSE NUMBER (of Licensee): FD01006015
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Fagen-Miller Funeral Homes FH83003035, 2828 Highway Avenue, Highland, Indiana 46322

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. Cancer of the Prostate
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.
Approximate Interval Between Onset and Death:

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

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):

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: J. Paik, M.D.
29c MEDICAL LICENSE NO: 30770
29d DATE SIGNED (Month Day Year): 12/26/96
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. PAIK, M.D. 200 Monticello Drive, Dyer, IN 46311

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature], M.D.
32 DATE FILED (Month Day Year): December 27, 1996

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.

000458

LAKE COUNTY HEALTH COMMISSIONER

FILED

SAM ORLICH AUDITOR LAKE COUNTY

97 ... 8 AM 11:17 FILED FOR RECORD ... STATE OF INDIANA ... MICHAEL ... RECORDER

#27-143-31, 31, 32, 33, 34, 30, 29, 10, 9, 8, 7, Ver 5

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