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. 748

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.

Sept. 29, 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): Francis Ellen Queen
2 SEX: Female
3a TIME OF DEATH: 11:20P M
3b DATE OF DEATH (Month Day Yr): September 25, 1997
4 SOCIAL SECURITY NUMBER: 316-03-6774
5a AGE—Last Birthday (Years): 76
5b UNDER 1 YEAR (Months Days):
5c UNDER 1 DAY (Hours Minutes):
6 DATE OF BIRTH (Mo Day Yr): Feb. 1, 1921
7 BIRTHPLACE (City and State or Foreign Country): Gilmon, IL
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 ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution give street and number): 925 175th St.
9c CITY TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Divorced
11 SURVIVING SPOUSE (If wife give maiden name): ----
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: Home
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 925 175th St.
13e ZIP CODE: 46320
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): 12; College (1 4 or 5 +): ---

PARENTS

18 FATHER'S NAME (First Middle Last): McKinley C. Meyer
19 MOTHER'S NAME (First Middle Maiden Surname): Mina Meyer

INFORMANT

20a INFORMANT'S NAME (Type/Print): Tim Chumley
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 11 Rimbach St. Hammond, IN 46320
20c Relationship: Son

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September, 1997 German Methodist Cemetery
21c LOCATION—City or Town State: Cedar Lake, IN
22a EMBALMER'S NAME: Brian T. Burns
22b EMBALMER'S LICENSE NO: 8601763
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Brian T. Burns
24b LICENSE NUMBER (of Licensee): 8601763
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #0002819 5840 Hohman Hammond, IN 46320

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. Chronic Obstructive Pulmonary Disease — Approximate Interval Between Onset and Death: 10 yr
DUE TO (OR AS A CONSEQUENCE OF)
b. Emphysema — 10 yr
Conditions if any which gave rise to the immediate cause stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
c. Chronic Asthma — 5 yr
DUE TO (OR AS A CONSEQUENCE OF)
d. Hypertension — 5 yr

FILED OCT 03 1997 SAM ORLICH AUDITOR LAKE COUNTY

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)
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: Floyd Manley M.D.
29c DATE SIGNED (Month Day Year): 9/26/97
29d DATE SIGNED (Month Day Year): Sept. 26, 1997
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): F. Manley, M.D. 6010 Columbia Ave. Hammond, IN Lic # 01019249
31 HEALTH OFFICER'S SIGNATURE: Virginia L. Brennan M.D.
32 DATE FILED (Month Day Year): September 29, 1997

#32-116-16

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

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