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. 2443-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): BERNDENA McCLESKEY
2 SEX: FEMALE
3a TIME OF DEATH: 8:43 A
3b DATE OF DEATH (Month Day Yr): OCT.26,1995
4 SOCIAL SECURITY NUMBER: 178-26-3093
5a AGE—Last Birthday (Years): 62
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): JULY 11,1933
7 BIRTHPLACE (City and State or Foreign Country): BRADFORD WOODS, PENN
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: NO
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): METHODIST HOSPITAL SOUTHLAKE CAMPUS
9c CITY, TOWN OR LOCATION OF DEATH: MERRILLVILLE
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): MERLE F McCLESKEY
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEAMKER
12b KIND OF BUSINESS/INDUSTRY: AT HOME
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: CROWN POINT
13d STREET AND NUMBER: 12404 Kingfisher Road
13e ZIP CODE: 46307
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): ELLSWORTH STEELE
19 MOTHER'S NAME (First Middle Maiden Surname): DIENA JANNABER

INFORMANT

20a INFORMANT'S NAME (Type/Print): MERLE F McCLESKEY
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12404 Kingfisher Rd.,Crown Point,In 46307
20c Relationship: HUSBAND

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): October 28,1995 NORTHWEST IND. CREMATION SERVICES
21c LOCATION—City or Town, State: CROWN POINT INDIANA
22a EMBALMER'S NAME: N/A
22b EMBALMER'S LICENSE NO: N/A
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Terrence P Burns
24b LICENSE NUMBER (of Licensee): 1013890
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home,10101 Broadway Crown Point,IN 46307 FDH8300044

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... List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Bronchopneumonia
DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF): c. Ca of Uterus
DUE TO (OR AS A CONSEQUENCE OF): d.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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): N/A

Stamp: THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. OCT 30 1995 Alexander S. Williams, MD LAKE COUNTY HEALTH COMMISSIONER

Stamp: FILED NOV 12 1997 SAM ORLICH AUDITOR LAKE COUNTY

Stamp: STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97 NOV 12 AM 10:34 MORRIS W. CARTER RECORDER

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 Fadul
29c MEDICAL LICENSE NO: 01016574
29d DATE SIGNED (Month Day Year): 10/27/95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Armand Fadul, 8695 Connecticut, Merrillville, IN

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32 DATE FILED (Month Day Year): October 30,1995

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