James DAVIS
18911 Parrish Ave
Lowell, In. 46356

*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. 0673-97 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): Margaret A. Davis
2. SEX: Female
3a. TIME OF DEATH: 05:53A
3b. DATE OF DEATH (Month, Day, Yr): March 27, 1997
4. *SOCIAL SECURITY NUMBER: 564-64-3976
5a. AGE—Last Birthday (Years): 52
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): Jun 2, 1944
7. BIRTHPLACE (City and State or Foreign Country): Monroe, LA
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): St. Anthonys Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): ~~None~~ James L. Davis
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Assembler
12b. KIND OF BUSINESS/INDUSTRY: Factory
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 18911 Parrish St
13e. ZIP CODE: 46356
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph D. Standard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Marie L. Jones

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Wendy Fields
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18911 Parrish St. Lowell, IN 46356
20c. Relationship: Daughter

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 31, 1997 Oakland Memory Lanes
21c. LOCATION—City or Town, State: Dolton, Illinois
22a. EMBALMER'S NAME: Byron G. Hawkins
22b. EMBALMER'S LICENSE NO.: FD29500038
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Molly E. Hawkins
24b. LICENSE NUMBER (of Licensee): FD09200061
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): Congestive Heart Failure — months
DUE TO (OR AS A CONSEQUENCE OF): Dilated Cardiomyopathy — months
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease — years
DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Type II Diabetes mellitus; post coronary Artery Bypass; previous Myocardial [illegible]

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): NA

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) and manner 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: Richard Krejsa - Physician
29c. MEDICAL LICENSE NO.: 02001002
29d. DATE SIGNED (Month, Day, Year): March 27, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Richard Krejsa DO, 2068 Lucas Parkway, Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): March 27, 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.

000527 9.00

Key #1-134-B County Heaven Unit #2 Lot 19

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
MAR 31 1997
LAKE COUNTY HEALTH COMMISSIONER
FILED
DEC 1997
SAM ORLICH AUDITOR LAKE COUNTY
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
DEC PM 3:38
CARTER

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