Beckman, Hadley Smith
5920 Hohman Ave
Hammond, IN 46320-2423

Local No. 0496-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOHN R. O'CONNOR
2. SEX: MALE
3a. TIME OF DEATH: 5:22A.M
3b. DATE OF DEATH (Month, Day, Yr): MARCH 4, 1991
4. SOCIAL SECURITY NUMBER: 340-09-4862
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr): OCTOBER 23, 1913
7. BIRTHPLACE (City and State or Foreign Country): Athol, South Dakota
8a. WAS DECEDENT A US VETERAN?: Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): 234 HOLLY LANE
9c. CITY, TOWN, OR LOCATION OF DEATH: SCHERERVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): LETHORNE McMAHON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FUNERAL DIRECTOR
12b. KIND OF BUSINESS/INDUSTRY: FUNERAL SERVICE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: SCHERERVILLE
13d. STREET AND NUMBER: 234 HOLLY LANE
13e. ZIP CODE: 47580
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+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): EMERY M. O'CONNOR
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANETTE MARIE KING

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LETHORNE O'CONNOR
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 234 HOLLY LANE, SCHERERVILLE, IN. 47580
20c. Relationship: WIFE

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): MARCH 7, 1991 ST. MARY CEMETERY
21c. LOCATION—City or Town, State: EVERGREEN PARK, ILLINOIS
22a. EMBALMER'S NAME: LEO V. HENNESSY
22b. EMBALMER'S LICENSE NO: IL #29-010388
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
24b. LICENSE NUMBER (of Licensee): 1051840
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: #3002893 SOLAN F.H. 7109 CALUMET AV HAMMOND, IN for NOWAK FUNERAL HOME, CALUMET CITY, I

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): a. metastatic carcinoma — yrs
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
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): no

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

LAKE COUNTY HEALTH COMMISSIONER

MAR 1 1991

970875

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

FILED DEC 18 1997 SAM ORLICH AUDITOR LAKE COUNTY

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: [signature]
29c. MEDICAL LICENSE NO: 01026259
29d. DATE SIGNED (Month, Day, Year): 03-04-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Gleaton MD 7905 Calumet Ave., Munster, Ind.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): March 5 1991

CORONER USE ONLY

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.

001128

900 0043318 ck

LN 1.00 ret

SBH06-004 State Form 10110 (R2/3-89)