Local No. 14169-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC 23 PM 2:32

State No. ....

9700088173

15cc's

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): ALICE E. DAVIDSON
2 SEX: Female
3a TIME OF DEATH: 11:45P M
3b DATE OF DEATH (Month Day Yr): July 17, 1991
4 SOCIAL SECURITY NUMBER: 313-07-1309
5a AGE—Last Birthday (Years): 83
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): DEC 8, 1907
7 BIRTHPLACE (City and State or Foreign Country): SCOTTDALE, PENNSYLVANIA
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH: HOBART
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): Widowed
11 SURVIVING SPOUSE (If wife, give maiden name): NONE
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): REGIONAL MERCHANDISER
12b KIND OF BUSINESS/INDUSTRY: MONTGOMERY WARD & CO
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 6316 GRAND BLVD.
13e ZIP CODE: 46342
13f INSIDE CITY LIMITS: ☐ No [X] Yes
13g ON A FARM?: [X] No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): CALEB C. SMITH
19 MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE B. FAIR

INFORMANT

20a INFORMANT'S NAME (Type/Print): PATRICK T. O'BRIEN
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RR# 1, REDKEY, IN 47373
20c Relationship: Nephew

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) ______
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JUL 20, 1991 CALUMET PARK CEMETERY
21c LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a EMBALMER'S NAME: JAMES W. GHOLSTON
22b EMBALMER'S LICENSE NO: FDO1004194
23 WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b LICENSE NUMBER (of Licensee): FDO1006463
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

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. peritonitis	4 days
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) b. acute myelogenous leukemia	months
	DUE TO (OR AS A CONSEQUENCE OF) c.	
	DUE TO (OR AS A CONSEQUENCE OF) d.	

FILED
DEC 29 1997
SAM ORLICH
AUDITOR LAKE COUNTY

PART II. Other significant conditions - Conditions contributing to death but not related to cause 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

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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] MD
29c MEDICAL LICENSE NO: 01020846
29d DATE SIGNED (Month, Day, Year): 7/19/91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DONALD PHILLIPS, MD, 1356 S. LAKE PARK AVE, HOBART, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32 DATE FILED (Month, Day, Year): Jul 29 1991

CORONER USE ONLY

33 MANNER OF DEATH: [X] 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.

COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
DEC 19 1997
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

001330

TICOR TITLE INSURANCE
Crown Point, Indiana
214893
53-2-2

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1