

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

INDIANA STATE DEPARTMENT OF HEALTH

KEY 36-505-24

Local No. 0766-98

CERTIFICATE OF DEATH

State No.

42816

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

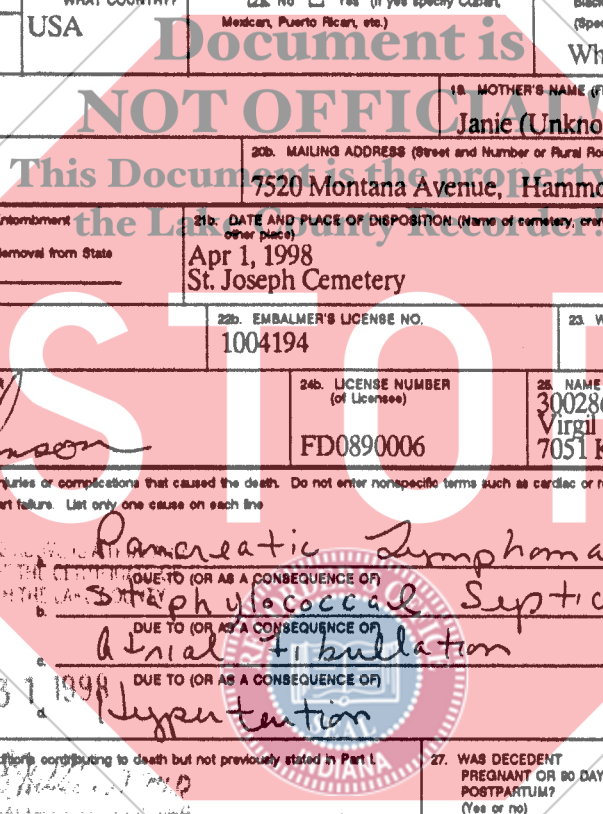
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) James William Babbitt		2. SEX Male	3a. TIME OF DEATH 7:10PM	3b. DATE OF DEATH (Month Day Yr) March 28, 1998	
4. SOCIAL SECURITY NUMBER 400-20-7192	5a. AGE - Last Birthday (Years) 75	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Sep 3, 1922	
7. BIRTHPLACE (City and State or Foreign Country) Whitesville, KY	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1946	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify) Hospice <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) Hospice of Calumet Area		9b. CITY TOWN OR LOCATION OF DEATH Munster	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Mary Ellen	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Forging operator		12b. KIND OF BUSINESS INDUSTRY Steel fabricators	
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hammond	13d. STREET AND NUMBER 7520 Montana Avenue 2		
13e. ZIP CODE 46323	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian (Black, White, etc. (Specify) White	
17. DECEASED'S EDUCATION (Specify highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 6		18. FATHER'S NAME (First, Middle, Last) Hallie Babbitt			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Janie (Unknown)		20a. INFORMANT'S NAME (Type/Print) Mary Ellen Babbitt			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Montana Avenue, Hammond, IN 46323		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Apr 1, 1998 St. Joseph Cemetery		21c. LOCATION - City or Town State Hammond, IN	
22a. EMBALMER'S NAME James W. Gholston		22b. EMBALMER'S LICENSE NO. 1004194	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>LeRoy Johnson</i>		24b. LICENSE NUMBER (of License) FD0890006	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323		
26. PART I. List 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 (The disease or condition resulting in death) Pancreatic lymphoma Staphylococcal Septicemia Atrial Fibrillation Hypertension DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) MAR 31 1998			26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Allyl alcohol toxicity</i>		
27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO			28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		
28b. WAS AN ANATOMICAL EXAMINATION PERFORMED? (Yes or no) NO			28c. WAS THE CAUSE OF DEATH COMPLETED? (Yes or no) NO		
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.					
29a. SIGNATURE AND TITLE OF CERTIFIER <i> Kenneth A. Rensub</i>			29b. MEDICAL LICENSE NO 02001574	29c. DATE SIGNED (Month Day Year) 3/30/98	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ken Perez, M.D., 9131 Indianapolis, Highland, IN 46322					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>			32. DATE FILED (Month Day Year) March 31, 1998		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			



STATE OF INDIANA
LAKE COUNTY
FILED
APR 6 1998
SAM OBLICH
AUDITOR LAKE COUNTY

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f/m

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