

* 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

State No.

Local No. 0728-98

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) KENNETH FRANK BEATTY		2 SEX Male	3a TIME OF DEATH 11:51 A M	3b DATE OF DEATH (Month Day Yr) March 24, 1998
4 SOCIAL SECURITY NUMBER 163-20-2999	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) May 7, 1926
7 BIRTHPLACE (City and State or Foreign Country) Greenville, Pennsylvania	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? -	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

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) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Ruth Qualk	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Truck Driver	12b KIND OF BUSINESS/INDUSTRY Construction

PARENTS

13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 81 Indian Trail
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		

INFORMANT

18 FATHER'S NAME (First Middle Last) Wilson James Beatty	19 MOTHER'S NAME (First Middle Maiden Surname) Mary Gertrude Haggerty	
20a INFORMANT'S NAME (Type/Print) Ruth L. Beatty	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 81 Indian Trail Merrillville, IN 46410	20c Relationship Wife

DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <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) March 28, 1998 Graceland Cemetery	21c LOCATION—City or Town, State Valparaiso, Indiana
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CAUSE OF DEATH

22a EMBALMER'S NAME Robert A. Craigin Jr.	22b EMBALMER'S LICENSE NO. FDO8700735	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mearns</i>	24b LICENSE NUMBER (of Licensee) FDO1005912	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410

26. PART I Enter the disease, injury, 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)
Multi Systems Failure

HEALTH OFFICER COUNTY
**Due to (or as a consequence of)
Low Cardiac output and Congestive Pathy**

CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST
**due to (or as a consequence of)
open heart surgery - Coronary artery bypass and Mitral Valve replacement**

MAR 27 1998

CERTIFIER

PART II Only specific conditions. Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 60 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**

HEALTH OFFICER

29a 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.	29b SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Veera Ponpaiboon, M.D.</i>	29c MEDICAL LICENSE NO. 01025643	29d DATE SIGNED (Month Day Year) 3/26/98
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Dr. Veera Ponpaiboon, M.D., 8687 Connecticut Street Merrillville, IN 46410			
31 HEALTH OFFICER'S SIGNATURE <i>Alexander J. Gillen, M.D.</i>		32 DATE FILED (Month Day Year) March 27, 1998	

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY BY TWO? (Yes or No)	34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f ADDRESS (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) (Yes, specify driver, passenger, pedestrian, etc.)
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FILED

JUN 26 1998

SAM ORLICH

AUDITOR LAKE COUNTY

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