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Juanita B. Muller  
101724512  
New Buffalo mi

INDIANA STATE DEPARTMENT OF HEALTH

95-0260

CERTIFICATE OF DEATH

State No. 49117

Local No. ....

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

Key #48-41-142  
East Gary Gardens  
lots 1+2 Block 2

1. DECEASED - NAME (First, Middle, Last) Reed Adams		2. SEX Male		3a. TIME OF DEATH PM 3:00 pm		3b. DATE OF DEATH (Month, Day, Yr.) March 22, 1995	
4. SOCIAL SECURITY NUMBER 99084923		5a. AGE - Last Birthday (Years) 78		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6a. WAS DECEDENT A U.S. VETERAN? NO		6b. YEAR LAST SERVED IN U.S. ARMED FORCES?		6. DATE OF BIRTH (Mo, Day, Yr.) February 20, 1917			
7. BIRTHPLACE (City and State or Foreign Country) Letcher County, KY		8a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
8b. FACILITY NAME (If not institution, give street and number) Northwest Family Hospital			8c. CITY, TOWN, OR LOCATION OF DEATH Gary			8d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, given maiden name) Mary (Ball)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not list retired) Machine Operator		12b. KIND OF BUSINESS/INDUSTRY Gary Screw and Bolt	
13a. RESIDENCE - STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Lake Station		13d. STREET AND NUMBERS 2262 Cass Street	
13e. ZIP CODE 46405		13f. INSIDE CITY LIMITS? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. FATHER'S NAME (First, Middle, Last) Joe Adams		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary / Secondary (0-12) <input checked="" type="checkbox"/> College (14 or 15+) <input type="checkbox"/> 6		18. RACE - American Indian, Black, White, etc. (Specify) White		19. MOTHER'S NAME (First, Middle, Maiden Surname) Ella (Cornett) Adams	
20a. INFORMANT'S NAME (Type/Print) Mary (Ball) Adams			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2262 Cass Street, Lake Station, IN 46405			20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" 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 25, 1995 Evergreen Memorial Park		21c. LOCATION - City or Town, State Hobart, IN			
22a. EMBALMER'S NAME Vernon R. Engel		22b. EMBALMER'S LICENSE NO. FDO 9200094		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Vernon R. Engel</i>		24b. LICENSE NUMBER (of Licensee) FDO 9200094		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Engel Funeral Home FDH 3007893 2700 Willowcreek Road, Portage, IN 46368			
25. 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiac Arrhythmia b. Pulmonary Hypertension c. COPD d. Coal Miner's Lung Conditions, if any, which gave rise to the immediate cause stating the underlying cause last							Approximate Interval Between Onset and Death
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
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>Don S. Dunevant MD</i>			29b. MEDICAL LICENSE NO. #01033863		29c. DATE SIGNED (Month, Day, Year) 3-31-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Don S. Dunevant MD 6040 Lute Rd., Portage, IN 46368							
31. HEALTH OFFICER'S SIGNATURE <i>Peter Benjamin</i>			32. DATE FILED (Month, Day, Year) APR 03 1995			FILED	
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"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) OCT 14 1999		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9.00 E.P. CS		34f. DESCRIBE HOW INJURY OCCURRED			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify.			

PETER BENJAMIN  
LAKE COUNTY AUDITOR

000932