INDIANA STATE BOARD OF HEALTH

Local No. 757-90

CERTIFICATE OF DEATH

State No. .....

STATE OF INDIANA
LAKE COUNTY
FILED 2:05 P.M.
99 OCT 20 AM 10:10
MORRIS RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): BERNADETTE F. BEVILLE
2. SEX:
3a. TIME OF DEATH:
3b. DATE OF DEATH (Month, Day, Yr.): MARCH 29, 1990
4. SOCIAL SECURITY NUMBER: 316-03-5923
5a. AGE—Last Birthday: 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): JUNE 7, 1919
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, IND.
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
8c. PLACE OF DEATH (Check only one) (See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): STEVE C. BEVILLE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: MUNSTER
13d. STREET AND NUMBER: 8041 MONROE
13e. ZIP CODE: 46321
13f. INSIDE CITY LIMITS? ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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 YRS; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): DANIEL DULIN
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY SWALWELL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): STEVE BEVILLE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8041 MONROE, MUNSTER, IND. 46321
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MARCH 31, 1990 — CHAPEL LAWN CEMETERY
21c. LOCATION—City or Town, State: SCHERERVILLE, IND.
22a. EMBALMER'S NAME: THOMAS J. BURNS
22b. EMBALMER'S LICENSE NO.: 1045184
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS-KISH F H #3004968, 8415 CALUMET AVE, MUNSTER, IND./46321

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.	Mesenteric thrombosis	3 days
DUE TO (OR AS A CONSEQUENCE OF): b.	Emphysema	15 yrs.
DUE TO (OR AS A CONSEQUENCE OF): c.	Renal failure	7 days
DUE TO (OR AS A CONSEQUENCE OF): d.		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. IF FEMALE: PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no):
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): APR 3 1990
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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: Daniel Adler
29c. MEDICAL LICENSE NO.: LAKE COUNTY HEALTH COMMISSIONER
29d. DATE SIGNED (Month, Day, Year): 4-2-90

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. FRED ADLER, 800 MAC ARTHUR, MUNSTER, IND. 46321
31. HEALTH OFFICER'S SIGNATURE: Carol Johnson — OCT 20 1999
32. DATE FILED (Month, Day, Year): APR 3, 90

FILED

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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:

PETER BENJAMIN
LAKE COUNTY AUDITOR

9.00 EP CS
001300

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