

600

* 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

CERTIFICATE OF DEATH

State No.....

Local No. 2331-99

99087987

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER ICS-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) MATILDA McNORTON		2. SEX Female	3a. TIME OF DEATH 4:03AM	3b. DATE OF DEATH (Month Day Yr) October 13, 1999
4. SOCIAL SECURITY NUMBER 306-09-4735	5a. AGE - Last Birthday (Years) 82	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) February 11, 1917
7. BIRTHPLACE (City and State or Foreign Country) Nova Scotia	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8c. 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	
9a. FACILITY NAME - (If not institution, give street and number) St. Mary Medical Center		9b. CITY TOWN OR LOCATION OF DEATH Hobart	9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) William McNorton	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sorter	12b. KIND OF BUSINESS INDUSTRY Steel	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Lake Station	13d. STREET AND NUMBER 2430 Old Hobart Road	
13e. ZIP CODE 46405	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. FATHER'S NAME (First Middle, Last) Peter J. Judge		16. MOTHER'S NAME (First Middle, Maiden Surname) Winefred Neville		
20a. INFORMANT'S NAME (Type/Print) William McNorton		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2430 Old Hobart Road, Lake Station, IN 46405	20c. Relationship Husband	
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) October 16, 1999 Ridgeland Cemetery		21c. LOCATION - City or Town State FOR Gary, Indiana
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO HEALTH DEPARTMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of license) FDO1006463	24. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342	
26. PART I: Enter the disease, 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. <i>Coronary Heart Failure</i>		PETER BENJAMIN COUNTY 4		Approximate interval between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. DUE TO (OR AS A CONSEQUENCE OF)		
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b. DUE TO (OR AS A CONSEQUENCE OF)		
		c. DUE TO (OR AS A CONSEQUENCE OF)		
		d. DUE TO (OR AS A CONSEQUENCE OF)		
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
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>Milton Gasparis MD</i>		29c. MEDICAL LICENSE NO. 01037515	29d. DATE SIGNED (Month Day Year) 10-14-99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Milton Gasparis MD, 1400 S. Lake Park Avenue, Suite 301, Hobart, IN 46342				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>			32. DATE FILED (Month Day Year) October 14, 1999	
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 AT WORK? (Yes or no)
		34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED OCT 14 1999
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <i>Alexander S. Williams MD</i> LAKE COUNTY HEALTH COMMISSION		

9.00
C.P.
31131