3cc
2 uc
5 total

* 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

Local No. 717-99 282283

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
HARVEY E. DRAVES, SR.	Male	5:30AM	March 16, 1999

4. SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr)	7. BIRTHPLACE (City and State or Foreign Country)
316-03-6401	77			May 13, 1921	Michigan City, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES	9a. PLACE OF DEATH (Check only one. See Instructions)
Yes	1945	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Mary Medical Center	Hobart	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS INDUSTRY
Married	Wanda Collins	Bridge Builder	Steel

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	344 N. Cavender Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE - American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	Elementary/Secondary (0-12): 11 — College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Harvey Draves	Lucille Chatterson

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Wanda Draves	344 N. Cavender Street, Hobart, IN 46342	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION - City or Town State
☐ Burial ☒ Cremation ☐ Entombment ☐ Donation ☐ Other (Specify) ☐ Removal from State	March 19, 1999 Calvary Crematory	Portage, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FDO1006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FDO1006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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)	Cardio Respiratory Arrest	20 Minutes
DUE TO (OR AS A CONSEQUENCE OF) b.	Chronic Obstructive Lung Disease	10 Years
DUE TO (OR AS A CONSEQUENCE OF) c.	Congestive Cardiac Failure	5 Years
DUE TO (OR AS A CONSEQUENCE OF) d.	Enlarged Prostate	10 Years

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

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

27. WAS DECEDENT PREGNANT WITHIN 90 DAYS (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
	01031797	March 18, 1999

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Shashikant R. Rane MD, 10 N. Michigan Avenue, Hobart, IN 46342

31. HEALTH OFFICER'S SIGNATURE Alexander S. Williams, M.D.

32. DATE FILED (Month Day Year) March 18, 1999

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, etc.

9.00 CASH

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1