THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Dec. 10, 1993 — Date Issued — Hammond Health Commissioner

STATE OF INDIANA
INDIANA STATE DEPARTMENT OF HEALTH
FILED FOR RECORD
CERTIFICATE OF DEATH

Local No. 1019

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2000 MAR 9 07

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3 07

2000 015260

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Decedent's Name (First, Middle, Last)	MARGARET L. TURNER
2. Sex	FEMALE
3a. Time of Death	1:32 A.M.
3b. Date of Death (Month, Day, Yr.)	December 6, 1993
4. Social Security Number	306-10-0924
5a. Age—Last Birthday (Years)	77
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo, Day, Yr)	August 11, 1916
7. Birthplace (City and State or Foreign Country)	WHITING, INDIANA
8a. Was Decedent a U.S. Veteran?	NO
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. Facility Name (If not institution, give street and number)	951 REESE AVENUE
9c. City, Town, or Location of Death	Hammond (P.O.Whiting)
9d. County of Death	LAKE ~~951 REESE AVE.~~
10. Marital Status (Specify)	Widowed
11. Surviving Spouse (If wife, give maiden name)	N/A
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Teller
12b. Kind of Business/Industry	Banking
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town or Location	Hammond (P.O.Whiting)
13d. Street and Number	951 Reese Avenue
13e. Zip Code	46394
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	WHITE
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	JOSEPH BELLAN
19. Mother's Name (First, Middle, Maiden Surname)	LILLIAN (Maiden surname unknown)

INFORMANT

Field	Value
20a. Informant's Name (Type/Print)	FLOYD J. TURNER
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2006 Superior Ave., Whiting, IN 46394
20c. Relationship	SON

DISPOSITION

Field	Value
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	08 December 1993 ST. JOHN CEMETERY
21c. Location—City or Town, State	HAMMOND, INDIANA
22a. Embalmer's Name	THOS. OWENS
22b. Embalmer's License No.	FDE 1001049
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Thos Owens
24b. License Number (of Licensee)	FDE 1001049
25. Name, Address, and License Number of Funeral Home	OWENS FUNERAL HOME FDH3007291 816-119th St., Whiting, IN 46394

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Metastatic cancer	
DUE TO (OR AS A CONSEQUENCE OF): b.	Renal cancer	
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

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 or 90 Days Postpartum? (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	N/A

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)
[signature] D.O.	02000216	Dec 10-93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. WILLIAM V GARVIN DO 1010 119th STR WHITING IN. 46394

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin F.O. [signature] M.D.

32. DATE FILED (Month, Day, Year): December 10, 1993

CORONER USE ONLY

33. Manner of Death	34a. Date of Injury (Month, Day, Year)	34b. Time of Injury	34c. Injury at Work? (Yes or no)	34d. Describe How Injury Occurred
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)

00345 9.00 pd

34g. DATE PRONOUNCED DEAD (Month, Day, Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

3908

Danko, Goldsmith & Ritzi, 1500-119 St., P.O. Box 570, Whiting, In. 46394

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1