

\* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

STATE OF INDIANA  
LAKE COUNTY  
INDIANA STATE DEPARTMENT OF HEALTH

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

Local No. 854 2000 CERTIFICATE OF DEATH MAR -2 AMSC 11471999  
Old Issued  
Franklin D. Premuda  
Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

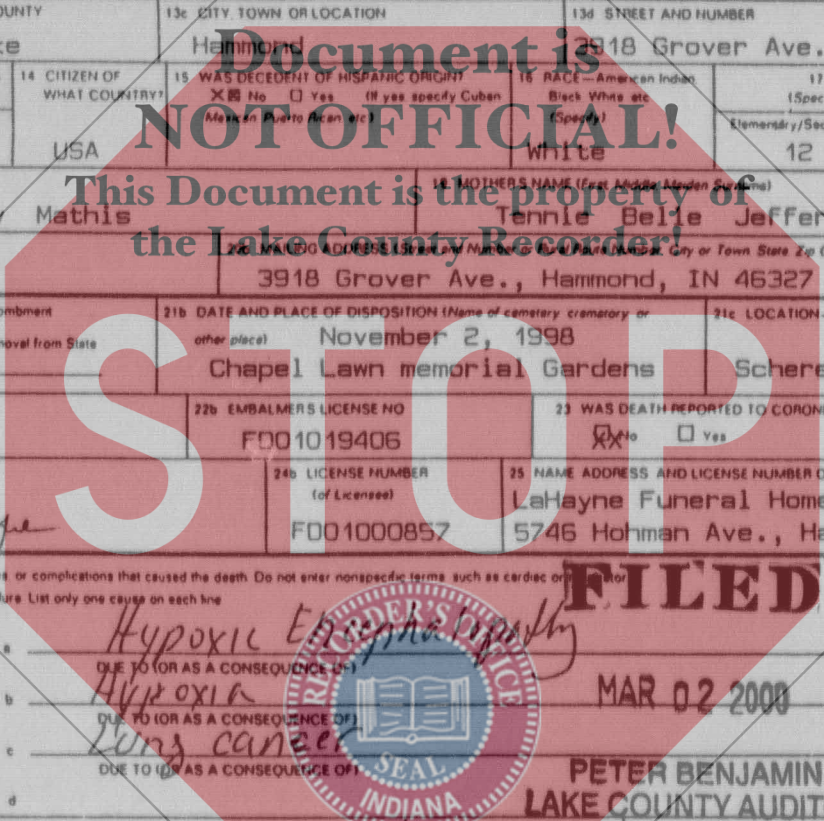
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) James P. Mathis		2 SEX Male	3a TIME OF DEATH RECORDED 1:00 P.M.	3b DATE OF DEATH (Month Day Yr.) October 30, 1998
4 *SOCIAL SECURITY NUMBER 386-12-8397	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr.) December 18, 1924
7 BIRTHPLACE (City and State or Foreign Country) Hardin, KY	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 3918 Grover Ave.,	9c CITY TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake	2000	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Eugenia Flynn	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Insurance Auditor	12b KIND OF BUSINESS/INDUSTRY Hartford Insurance Co.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 3918 Grover Ave.,	
13e ZIP CODE 46327	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 RACE—American Indian Black White etc. (Specify) white
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (12) College (14 or 16)	18 FATHER'S NAME (First Middle Last) Toy Ray Mathis	19 MOTHER'S NAME (First Middle Maiden Surname) Tennie Belle Jeffery		20c Relationship Wife
20a INFORMANT'S NAME (Type/Print) Eugenia Mathis	20b HOME ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3918 Grover Ave., Hammond, IN 46327			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) November 2, 1998 Chapel Lawn memorial Gardens		21c LOCATION—City or Town, State Schererville, IN	
22a EMBALMER'S NAME Henry J. Blake	22b EMBALMER'S LICENSE NO. F001019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edwin B. Sakay</i>	24b LICENSE NUMBER (of Licensee) F001000857	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc., IN830028 5746 Hohman Ave., Hammond, IN 46320		
26 PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) a Hypoxic Encephalopathy b Hypoxia c Lung cancer d 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>Christopher J. McIntire D.O.</i>		
29c MEDICAL LICENSE NO. 02001515		29d DATE SIGNED (Month Day Year) October 31, 1998		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Christopher J. McIntire, D.O., 3831 Hohman Ave., Hammond, IN 46327				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Premuda M.D.</i>				32 DATE FILED (Month Day Year) November 2, 1998
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 DESCRIBE HOW INJURY OCCURRED 2 over
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) 00523 9.00 EP		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian, etc. 0376		



STATE OF INDIANA  
LAKE COUNTY  
RECORDER

STATE OF INDIANA  
LAKE COUNTY  
RECORDER  
FILED  
MAR 02 2000