10 cc's + VETS

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 2194-99

282394

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED - NAME (First, Middle, Last)	Edward S. Olis
2 SEX	Male
3a TIME OF DEATH	2:35 AM
3b DATE OF DEATH (Month Day Year)	September 27, 1999
4 *SOCIAL SECURITY NUMBER	311-16-2537
5a AGE - Last Birthday (Years)	78
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	February 18, 1921
7 BIRTHPLACE (City and State or Foreign Country)	Pennsylvania
8a WAS DECEDENT A U S VETERAN?	Yes
8b YEAR LAST SERVED IN U S ARMED FORCES?	1945
PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	St. Mary Medical Center
9c CITY TOWN OR LOCATION OF DEATH	Hobart
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Nellie
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	Loader
12b KIND OF BUSINESS/INDUSTRY	U.S. Steel-Gary
13a RESIDENCE - STATE	Indiana
13b COUNTY	Lake
13c CITY TOWN OR LOCATION	Hobart
13d STREET AND NUMBER	844 Lake Street
13e ZIP CODE	46342
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)	12
College (1-4 or 5+)	N/A

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Frank Olis
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Theresa Shepp

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Nellie Olis
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	844 Lake Street, Hobart, IN 46342
20c Relationship	Wife

DISPOSITION

Field	Entry
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)	September 29, 1999 Calumet Park Cemetery
21c LOCATION - City or Town, State	Merrillville, Indiana
22a EMBALMER'S NAME	Gordon L. Jones
22b EMBALMER'S LICENSE NO	01010711
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	James E. Burns (signature)
24b LICENSE NUMBER (of Licensee)	FD01009461
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home FH83002380, 701 E. 7th Street, Hobart, Indiana 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)

a. acute Myocardial infarct

DUE TO (OR AS A CONSEQUENCE OF)

b. Cerebellar Infarct

DUE TO (OR AS A CONSEQUENCE OF)

c. Pneumonia

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

Field	Entry
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U)	N
28a WAS AN AUTOPSY PERFORMED? (Yes or no)	No
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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c MEDICAL LICENSE NO	01026059
29d DATE SIGNED (Month Day Year)	9-28-99
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Arun K. Goel 209 E. 86th Court, Merrillville, IN 46410

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD
32 DATE FILED (Month Day Year)	September 29, 1999

Field	Entry
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	

FILED

MAR 15 2000

PETER BENJAMIN

LAKE COUNTY AUDITOR

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

SEP 29 1999

Alexander S. Williams MD

LAKE COUNTY HEALTH COMMISSIONER

41093

State Form 10110 (R4/3-93) Deathcer/DB 1

Lot #27 Key #17-25-27 17-36 R7 SW 1/4 NE SW ... Pt S 1/2

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9.00 Lk Cust