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PORTER COUNTY
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

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): Emery A. Badanish
2. SEX: Male
3a. TIME OF DEATH: 6:05 AM
3b. DATE OF DEATH (Month, Day, Yr.): December 30, 1999
4. SOCIAL SECURITY NUMBER: 313-34-3966
5a. AGE - Last Birthday (Years): 90
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): August 09,1909
7. BIRTHPLACE (City and State or Foreign Country): Fordham Pennsylvania
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: —
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): VNA Mary Bartz Hospice Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Rosemary
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Pharmacist
12b. KIND OF BUSINESS/INDUSTRY: Pharmacy
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 6837 Forrest Avenue
13e. ZIP CODE: 46403
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 (0-12): 12; College (1-4 or 5+): 5+

PARENTS

18. FATHER'S NAME (First, Middle, Last): Jacob Badanish
19. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Stock

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Rosemary Badanish
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6837 Forrest Avenue, Gary, IN 46403
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 2, 2000 NW Indiana Cremation Service
21c. LOCATION - City or Town, State: Crown Point, Indiana
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home 701 E. 7th Street, Hobart, Indiana 46342- FH83002380

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.	Lung cancer	2 years
DUE TO (OR AS A CONSEQUENCE OF): b.		
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

FILED

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Chronic obstructive lung disease

27. WAS DECEDENT PREGNANT OR WITHIN 90 DAYS POSTPARTUM? (Yes or 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)

PETER BENJAMIN
LAKE COUNTY AUDITOR

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: Michael C. Weiss MD
29c. MEDICAL LICENSE NO.: 030965
29d. DATE SIGNED (Month, Day, Year): January 3, 2000
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Michael Weiss, M.D. 1101 East Glendale Blvd, Valparaiso, IN 46383

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Babcke MD
32. DATE FILED (Month, Day, Year): January 5, 2000

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): December 30, 1999
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

9.00 E.P.
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State Form 10110 (R4/3-93) Deathcer/PP 1