

* 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.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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

Oct. 8, 1999
S Date Issued Hammond Health Commissioner

Local No. 804

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

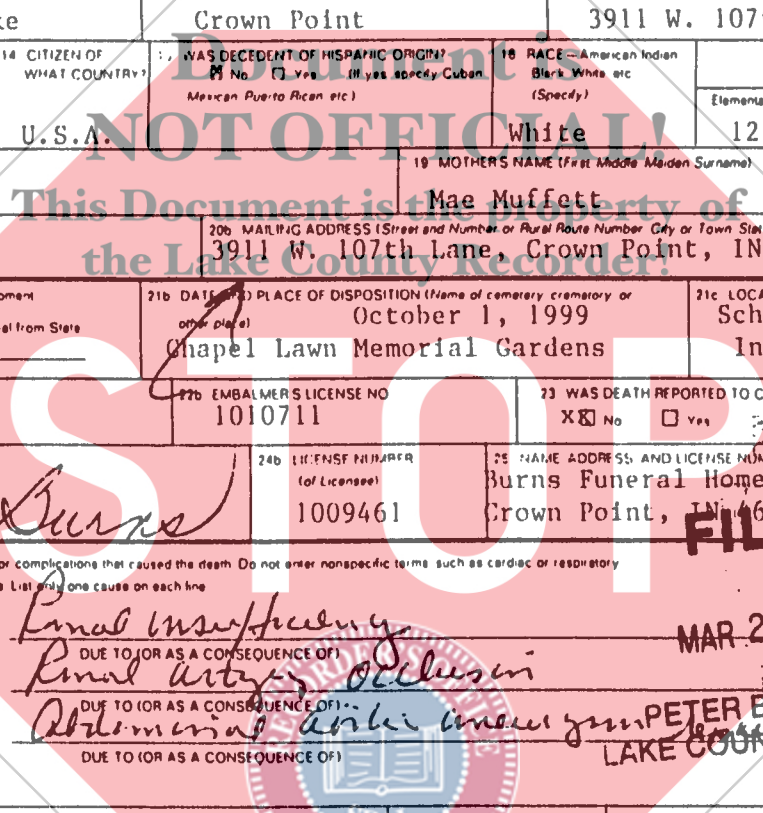
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Jean Toney		2 SEX Fe	3a TIME OF DEATH 2:48 p.m.	3b DATE OF DEATH (Month Day Year) Sept. 27, 1999
4 *SOCIAL SECURITY NUMBER 306-28-0870	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) Nov. 25, 1925
7 BIRTHPLACE (City and State or Foreign Country) Canalou, Missouri	8a WAS DECEDENT A U.S. VETERAN? Np			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/a	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution give street and number) Select Specialty Hospital		9c CITY TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Max Leonard Toney	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY At Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Crown Point	13d STREET AND NUMBER 3911 W. 107th One	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) <input checked="" type="checkbox"/> 12 College (1-4 or 5+) <input type="checkbox"/>		18 FATHER'S NAME (First Middle Last) William Arbuckle		
19 MOTHER'S NAME (First Middle Maiden Surname) Mae Muffett		20a INFORMANT'S NAME (Type, Print) Max Leonard Toney		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 W. 107th Lane, Crown Point, IN 46307		20c Relationship Husband		
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) October 1, 1999 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Scherverville Indiana
22a EMBALMER'S NAME Gordon L. Jones		22b EMBALMER'S LICENSE NO. 1010711		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24 SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b LICENSE NUMBER (of Licensee) 1009461	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10701 Broadway Crown Point, IN 46307 PH83002445	
26 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Renal insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Renal artery occlusion</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Abdominal aortic aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF) d.				
PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I <i>Renal insufficiency</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) N/.
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>Ronald R. Reed</i>			29c MEDICAL LICENSE NO. 18387	29d DATE SIGNED (Month Day Year) 10/8/99
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Ronald R. Reed, M.D., 3641 Ridge Road, Highland, IN 46322				
31 HEALTH OFFICER'S SIGNATURE <i>William J. Primmer, M.D.</i>				32 DATE FILED (Month Day Year) October 8, 1999
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



FILED
MAR 20 2000
INDIANA
LAKE COUNTY RECORDER

9.00
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