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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1996-93 State No.

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): LAWRENCE O MacBRIDE
2. SEX: MALE
3a. TIME OF DEATH: 1:45 PM
3b. DATE OF DEATH (Month, Day, Yr): AUGUST 17, 1993
4. SOCIAL SECURITY NUMBER: 570-68-6969
5a. AGE—Last Birthday (Years): 49
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MAY 7,1945
7. BIRTHPLACE (City and State or Foreign Country): PITTSBURGH,PENN
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1968
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): GAYLE NEIDETCHER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CONSULTANT
12b. KIND OF BUSINESS/INDUSTRY: SELF EMPLOYED
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 11426 DELAWARE STREET
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): C RHOADES MacBRIDE
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE OBERLIN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): GAYLE MacBRIDE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11426 DELAWARE ST, CROWN POINT, IN 46307
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): AUGUST 19,1993 NORTHWEST IND. CREMATION SERVICES
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?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P Burns
24b. LICENSE NUMBER (of Licensee): 1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home,10101 Broadway Crown Point,In 46307 FDH89002445

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Gastric Cancer — Approximate Interval Between Onset and Death: 2 mo

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.

PART II. Other significant 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): N/A

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: [signature]
29c. MEDICAL LICENSE NO.: 02000709
29d. DATE SIGNED (Month, Day, Year): 8/18/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr.Paul Schaffert,297 W. Franciscan Dr., Crown Point, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander Williams
32. DATE FILED (Month, Day, Year): August 19, 1993

FILED

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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? If Yes, specify if driver, passenger, pedestrian, etc.

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

THIS CERTIFIES THIS TO BE A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.

AUG 19 1993

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

PETER BENJAMIN
LAKE COUNTY AUDITOR

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

Valley View Add. Lot 10

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