

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

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
LAKE COUNTY

8cc
2ust
10 total

Local No. 1245-99

State No.

200717

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER 10-18-37-1-10

2000 021279

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) RICHARD B. SWALLOW		2. SEX Male	3. TIME OF DEATH 2:35PM	3b. DATE OF DEATH (Month Day Yr) May 21, 1999	
4. SOCIAL SECURITY NUMBER 478-16-4306	5a. AGE - Last Birthday (Years) 76	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) October 22, 1922	
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1946	8c. 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		
9a. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9b. CITY TOWN OR LOCATION OF DEATH Hobart		9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use related) Crane Operator		12b. KIND OF BUSINESS INDUSTRY Steel	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 1224 West 44th Place		
13e. ZIP CODE 46342	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 (0-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Harry M Swallow			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia Terrell		20a. INFORMANT'S NAME (Type/Print) Lillian Swallow			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 W. 44th Place Hobart, IN 46342		20c. Relationship Daughter			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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 place) May 25, 1999 Calvary Crematory		21c. LOCATION - City or Town State Portage, Indiana	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO FDO1006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>abdominal aortic aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF)				1 week	
Conditions if any which gave rise to the immediate cause stating the underlying cause last b. _____ DUE TO (OR AS A CONSEQUENCE OF)					
c. _____ DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
<i>end stage renal disease</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>[Signature]</i>		29c. MEDICAL LICENSE NO 01035956	29d. DATE SIGNED (Month Day Year) 5-24-99		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Maher Ajam MD, 8668 Broadway, Merrillville, IN 46459					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>				32. DATE FILED (Month Day Year) May 25, 1999	
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
		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) 00455	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 7.00 EP			