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

STATE OF INDIANA
COUNTY

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2145-95 2000 022769 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

FILED 2000 MAR -6 AM 9:21

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Sandra B. Williamson
2 SEX: Female
3a TIME OF DEATH: 11:10P M
3b DATE OF DEATH (Month Day Yr): September 21,1995
4 *SOCIAL SECURITY NUMBER: 310-48-4401
5a AGE—Last Birthday (Years): 48
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo. Day Yr): Dec. 11,1946
7 BIRTHPLACE (City and State or Foreign Country): Hammond,IN
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a PLACE OF DEATH (Check only one See instructions): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution give street and number): 1441 Muirfield Dr.
9c CITY, TOWN OR LOCATION OF DEATH: Dyer
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Joseph Williamson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Co-Owner/Operator
12b KIND OF BUSINESS/INDUSTRY: Retail
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Dyer
13d STREET AND NUMBER: 1441 Muirfield Dr.
13e ZIP CODE: 46311
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): William Blaemire
19 MOTHER'S NAME (First Middle Maiden Surname): Catherine Bailey

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joseph Williamson
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 1441 Muirfield Dr. Dyer,IN 46311
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 25,1995 Oakland Memory Lanes
21c LOCATION—City or Town State: Dolton,IL
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO: 1045964
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN 46321

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 Melanoma Stage IV — DUE TO (OR AS A CONSEQUENCE OF)
Approximate Interval Between Onset and Death: 3 Month
b — DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause stating the underlying cause last: c — DUE TO (OR AS A CONSEQUENCE OF)
d

FILED MAR 31 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 AUTOPSY (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): ---

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:
29c MEDICAL LICENSE NO: 01040756
29d DATE SIGNED (Month Day Year): September 25,199

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J.H.Gleaton, M.D. 7905 Calumet Munster,IN 46321
31 HEALTH OFFICER'S SIGNATURE: Abraham D. Gleaton, M.D
32 DATE FILED (Month Day Year): September 26,1995

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:

20096

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

Singleton Oral Austgen & Stare
9245 Calumet Ave Suite 280
Munster, In 46321