#36-204-43
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* **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

STATE OF INDIANA
LAKE COUNTY
FILED OF RECORD

Local No. 2507-98 State No.

42891

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): SAINT ELMO DANCER 2800 026837
2. SEX: MALE
3a TIME OF DEATH: 18:10 AM
3b DATE OF DEATH (Month Day Yr): NOVEMBER 14, 1998
4. SOCIAL SECURITY NUMBER: 429-26-1338
5a AGE—Last Birthday (Years): 80
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo. Day. Yr): MAY 29, 1918
7. BIRTHPLACE (City and State or Foreign Country): SPRINGFIELD, ARKANSAS
8a. WAS DECEDENT A U.S. VETERAN? YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Other (Specify) HOSPICE RESIDENCE ☐ Residence
9b FACILITY NAME (If not institution, give street and number): WILLIAM J. RILEY MEMORIAL RESIDENCE
9c. CITY, TOWN OR LOCATION OF DEATH: MUNSTER
9d COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): GERALDINE NOLAND
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CRANE OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: STEEL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: HAMMOND
13d STREET AND NUMBER: 4250 BALTIMORE AVENUE
13e ZIP CODE: 46327
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): 5; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): MELVIN DANCER
19 MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA MOORE

INFORMANT

20a INFORMANT'S NAME (Type/Print): GERALDINE DANCER
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4250 BALTIMORE AVENUE, HAMMOND, IN 46327
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): NOVEMBER 17, 1998 CONCORDIA CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a EMBALMER'S NAME: KEITH D. ANTHONY
22b EMBALMER'S LICENSE NO: 01011911
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b LICENSE NUMBER (of Licensee): 01011911
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835, 4404 CAMERON, HAMMOND, IN 46327

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 CARCINOMA OF LUNG.	
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):	
	d	

I CERTIFIED THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH WITH THE LAKE COUNTY HEALTH DEPARTMENT
NOV 16 1998
LAKE COUNTY HEALTH COMMISSIONER

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): NO

FILED
APR 19 2000
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: N. Sardesai M.D.
29c LICENSE NO: 24300
29d DATE SIGNED (Month Day Year): 11-16-1998

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): N. SARDESAI M.D. 9307 CALUMET AVENUE, MUNSTER
31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams III MD
32 DATE FILED (Month Day Year): November 16, 1998

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.

9.00
P.P.
CS

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

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