12-14-47-7

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 328-91 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Constance M. Beiriger
2. SEX	Female
3a. TIME OF DEATH	1:30 P M
3b. DATE OF DEATH (Month, Day, Yr.)	February 13, 1991
4. SOCIAL SECURITY NUMBER	316-48-2278
5a. AGE—Last Birthday (Years)	77
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	December 5,1913
7. BIRTHPLACE (City and State or Foreign Country)	Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	Methodist Hospital-Southlake Campus
9c. CITY, TOWN, OR LOCATION OF DEATH	Merrillville
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Widowed
11. SURVIVING SPOUSE (If wife, give maiden name)	
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	Own Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Dyer
13d. STREET AND NUMBER	1224 Madison Ave.
13e. ZIP CODE	46311
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Thomas Beggs
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Sarah Solon

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	William T. Beiriger
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1243 Brandywine Dr. Munster, Indiana46321
20c. Relationship	Son

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	February 16, 1991 St. Joseph Cemetery
21c. LOCATION—City or Town, State	Dyer, Indiana
22a. EMBALMER'S NAME	Edward F. Mullaney
22b. EMBALMER'S LICENSE NO.	FDO 1007176
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Edward F. Mullaney (signature)
24b. LICENSE NUMBER (of Licensee)	FDO 1007176
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83001504 Fagen-Miller Funeral Gardens Inc 1920 Hart St. Dyer, Indiana 46311

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. Pneumonia bilateral

DUE TO (OR AS A CONSEQUENCE OF):
b. Myocardial infarction

Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):
d.

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	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.	29d. DATE SIGNED (Month, Day, Year)
(signature)	01032180	February 14, 1991

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Surendra Shah M. D. 1110 W. 5th Ave. Gary, Indiana 46402

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S Williams M.D.	February 15, 1991

CORONER USE ONLY

Field	Entry
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	

31279 cash

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
LAKE COUNTY HEALTH COMMISSIONER

FILED APR 20 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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