1 Scc's

INDIANA STATE BOARD OF HEALTH

Local No. 2034-88 ..... CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo. Day. Yr.)
WILMA		STEPHENSON	FEMALE	SEPTEMBER 27,1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
310-28-5224	59			Mar.8,1929	CROWN POINT, INDIANA

DECEDENT

8 YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NEVER	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
1225 SOUTH LAKE PARK Selby Stevenson	HOBART	LAKE

10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
WIDOWED	NONE	HOMEMAKER	AT HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HOBART	1225 S. LAKE STREET

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban Mexican Puerto Rican etc)	15 RACE—American Indian Black White etc (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	No	46342	☒ No ☐ Yes	WHITE	N/A	N/A

PARENTS

17 FATHER'S NAME (First Middle Last)	18 MOTHER'S NAME (First Middle Maiden Surname)
WILLIAM FREDERICK GERNENZ	ANNA BERTHA WESLEY

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	19c Relationship
STEVEN A. STEPHENSON	66 VICTOR DRIVE HOBART, IN 46342	SON

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	20c LOCATION—City or Town State
☒ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	N.W. IN CREMATION SERVICE 9-30-88 EVERGREEN CEMETERY	CROWN POINT, IN HOBART, IN

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James F. Burns	1374	BURNS FUNERAL HOME 701 E.7TH ST.,HOBART, IN. 46342

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death	23a To the best of my knowledge death occurred at the time, date, and place stated Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED (Month. Day. Year)

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month. Day. Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
8:15 P.M. M	SEPTEMBER 27, 1988	YES

SEE INSTRUCTIONS

27 PART I Enter the diseases injuries, or complications that caused the death Do not enter the mode of dying 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 rectum with pulmonary emboli and	Unknown
Sequentially list conditions, if any, leading to immediate cause Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF) b malnutrition and dehydration	
	DUE TO (OR AS A CONSEQUENCE OF) c	
	DUE TO (OR AS A CONSEQUENCE OF) d	

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

CAUSE OF DEATH

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	Yes	Yes

SEE INSTRUCTIONS

CERTIFIER

29a CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician pronounced death and completed item 23)
To the best of my knowledge death occurred due to the cause(s) and manner as stated

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☒ CORONER ☐ 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) and manner as stated

FILED MAY 04 2000 LAKE COUNTY AUDITOR

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month. Day. Year)
Daniel D. Thomas M.D.	9420 PETER BENJAMIN LAKE COUNTY AUDITOR	Oct. 3,1988

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
DANIEL D. THOMAS,M.D., CORONER, 2293 N. MAIN ST. , CROWN POINT, IN. 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month. Day. Year)
	Oct. 3, 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				00691

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)

SBH06-004 State Form 10110 Rev 10/87 DEATH.PD1