* 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.

Local No. 461

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

June 6, 2000 — Date Issued

[signature] — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

2000 011593

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	Dane Earl
2. SEX	Male
3a. TIME OF DEATH	10:50 AM
3b. DATE OF DEATH (Month Day Yr)	June 4, 2000
4. *SOCIAL SECURITY NUMBER	316-05-4454
5a. AGE—Last Birthday (Years)	78
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	March 20, 1922
7. BIRTHPLACE (City and State or Foreign Country)	Romany, IN
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?	1945
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)	7818 Walnut Ave.,
9c. CITY, TOWN OR LOCATION OF DEATH	Hammond
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Dianne F. Morris
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Operating Engineer
12b. KIND OF BUSINESS/INDUSTRY	Local # 150
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Hammond
13d. STREET AND NUMBER	7818 Walnut Ave.,
13e. ZIP CODE	46324
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): 10; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	Fred Earl
19. MOTHER'S NAME (First Middle Maiden Surname)	Maude Slinker

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Dianne F. Earl
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7818 Walnut Ave., Hammond, IN 46324
20c. Relationship	Wife

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)	June 7, 2000 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State	Schererville, IN
22a. EMBALMER'S NAME	Henry J. Blake
22b. EMBALMER'S LICENSE NO	FD01019406
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature] Eldon B LeHayne
24b. LICENSE NUMBER (of Licensee)	FD01000857
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	LeHayne Funeral Home, Inc., FH194000 6955 Southeastern Ave., Hammond, IN46

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Metastatic Small Cell Lung Cancer	11 Months
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

Field	Entry
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

JUN 13 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Barbara L. Fuller, M.D.
29c. MEDICAL LICENSE NO	01034701
29d. DATE SIGNED (Month Day Year)	June 6, 2000
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Barbara Fuller, MD, 9305 Calumet Ave., Munster, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Franklin D. Bermudez M.D.
32. DATE FILED (Month Day Year)	June 6, 2000

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)	
34g. DATE PRONOUNCED DEAD (Month Day Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

Beverly 7th Add Lot 35 Block 1
Key# 32-204-35
unit # 26

900
SF
C9

00998

SDH06-004 State Form 10110 (R5/1-99)