

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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 State No. ....

Local No. 1765-00  
66 008

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

LAKE COUNTY  
FILED FOR RECORD

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEDENT—NAME (First, Middle, Last) <b>Warren H. Duvall</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>10:40 P.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>July 29, 2000</b>	
4. SOCIAL SECURITY NUMBER <b>402-22-5767</b>	5a. AGE AT DEATH (Month, Day, Year) <b>78</b>	5b. UNDER 1 DAY Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Da, Yr.) <b>Mar. 13, 1922</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Horsebranch, Kentucky</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) <b>5600 41st Ave.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Belma Jean Wells</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Line Production</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Gary (Calumet Township)</b>	13d. STREET AND NUMBER <b>5600 41st Ave.</b>		
13e. ZIP CODE <b>46408</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		18. FATHER'S NAME (First, Middle, Last) <b>William W. Duvall</b>			
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leona Renfrow</b>		20a. INFORMANT'S NAME (Type/Print) <b>Belma Jean Duvall</b>			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5600 41st Ave., Gary, Ind., 46408</b>		20c. Relationship <b>Wife</b>			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>August 2, 2000 Calumet Park Cemetery</b>		21c. LOCATION—City or Town, State <b>Merrillville, Indiana</b>	
22a. EMBALMER'S NAME <b>David R. Peterson</b>		22b. EMBALMER'S LICENSE NO. <b>FDO 8601585</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>David R. Peterson</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO 8601585</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 83007500</b>	
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. <b>Cardiovascular Arrest</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Cardiovascular Arrest</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Metastatic Prostate Carcinoma</b> ONSET OF CAUSE OF DEATH <b>Months</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Second</b>					
26. PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I. <b>AUG 01 2000</b> <i>Alexander S. Williams M.D.</i> LAKE COUNTY HEALTH COMMISSIONER					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>—</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>—</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>—</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>John A. Hoehn M.D.</i>			
29c. MEDICAL LICENSE NO. <b>#02000872</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/31/00</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) <b>Dr. John A. Hoehn, D.O. 505 West Lincoln Highway, Schererville, IN 46375</b>					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams M.D.</i>			32. DATE FILED (Month, Day, Year) <b>August 1, 2000</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) <b>FILED</b>	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 <b>AUG 11 2000</b>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify date and location. <b>PETER BENJAMIN 846 900</b> <b>LAKE COUNTY AUDITOR</b>			

DECEDENT

ARENTS

FORMANT

POSITION

USE OF  
ATH

RTIFIER

ALTH  
FICER

J.H. Wein's Black Oak Sub Lot 2 Block 2  
U.N. #441  
Key #49-488-2