ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0299-94 State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First, Middle, Last)	Eva B. Callow
2. SEX	female
3a. TIME OF DEATH	7:45 p M
3b. DATE OF DEATH (Month, Day, Yr.)	January 31, 1994
4. SOCIAL SECURITY NUMBER	307-40-6065
5a. AGE—Last Birthday (Years)	96
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	September 27, 1897
7. BIRTHPLACE (City and State or Foreign Country)	Waterford Twp., Illinois
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 ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	Munster Med-Inn
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)	Henry Callow
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Housewife
12b. KIND OF BUSINESS/INDUSTRY	Homemaker
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	4828 Chestnut St.
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? (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+)	4 /

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	Charles H. Standard
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Mary Ellen Howarth

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Arnette Jankowski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	829 River Dr., Hammond, Indiana 46324
20c. Relationship	Daughter

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	February 3, 1994 Elmwood Cemetery
21c. LOCATION—City or Town, State	Hammond, Indiana
22a. EMBALMER'S NAME	Dean G. Wagner
22b. EMBALMER'S LICENSE NO.	FD# 8800057
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Mary Solan
24b. LICENSE NUMBER (of Licensee)	FD# 1004097
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	SOLAN FUNERAL HOME FH# 83002893 7109 Calumet Ave., Hammond, Ind. 46324

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

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. Possible Acute Coronary Event

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

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

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

FEB 0 3 1994

Alexander S. Williams MD

LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Senility, Cellulitis - Decubitus ulcer

Field	Value
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)	--

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	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature] MD
29c. MEDICAL LICENSE NO.	01027498
29d. DATE SIGNED (Month, Day, Year)	2/1/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	JOHN F. PEREZ MD 8905 CALUMET AVE, MUNSTER, IN 46321

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year)	February 2, 1994

FILED AUG 4 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

Field	Value
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.	

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9.00 AC