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

Local No. 1999-00

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED–NAME (First Middle Last): BILLY J. FARRIS
2. SEX: Male
3a. TIME OF DEATH: 9:45AM
3b. DATE OF DEATH (Month Day Yr): August 5, 2000
4. SOCIAL SECURITY NUMBER: 322-30-8441
5a. AGE - Last Birthday (Years): 63
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): May 17, 1937
7. BIRTHPLACE (City and State or Foreign Country): Marshall, Illinois
8a. WAS DECEDENT A U.S VETERAN? Yes
8b. YEAR LAST SERVED IN U.S ARMED FORCES: 1957
8c. 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): 2251 Vigo St.
9c. CITY TOWN OR LOCATION OF DEATH: Lake Station
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Sandra Comstock
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Steelworker
12b. KIND OF BUSINESS INDUSTRY: Steel Manufacture
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Lake Station
13d. STREET AND NUMBER: 2251 Vigo St.
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE - American Indian Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): James Farris
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Beltz

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Sandra Farris
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2251 Vigo St., Lake Station, IN 46405
20c. Relationship: Wife

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): August 9, 2000 CALVARY CEMETERY
21c. LOCATION - City or Town State: PORTAGE, Indiana
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Charles D. Rees Jr.
24b. LICENSE NUMBER (of Licensee): FD01006049
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19300009 Rees Funeral Home, Brady Chapel 3781 Central Avenue, Lake Station, IN 46405

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

AUG 08 2000

27. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Alexander D. Williams MD LAKE COUNTY HEALTH COMMISSIONER
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

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

FILED AUG 23 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: MS Gasparis MD
29c. MEDICAL LICENSE NO: 01037515
29d. DATE SIGNED (Month Day Year): 8-8-00

**HEALTH OFFICER**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): MILTON S. GASPARIS MD, 1400 S. LAKE PARK AVE., SUITE 301, HOBART, IN 46342
31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams MD
32. DATE FILED (Month, Day Year): August 8, 2000

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): 01778
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc

A.C. 9.07
MD 9712687149

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