

2000-062/68

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 557-00
303100
TYPE/PRINT
IN
PERMANENT
BLACK INK

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

1 DECEASED—NAME (First Middle Last) EDWARD B. NEVERS		2 SEX Male		3a TIME OF DEATH 6:20 A.M.		3b DATE OF DEATH (Month Day Yr) February 29, 2000	
4 *SOCIAL SECURITY NUMBER 312-10-0784		5a AGE—Last Birthday (Years) 92		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) June 20, 1907		7 BIRTHPLACE (City and State or Foreign Country) Otis, Indiana					
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) Methodist Southlake				9c CITY, TOWN OR LOCATION OF DEATH Merrillville		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Dorothy Durco		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Retired Security Guard		12b KIND OF BUSINESS/INDUSTRY Calumet College	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7137 Jarnecke Avenue	
13e ZIP CODE 46324		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0					
18 FATHER'S NAME (First Middle Last) Jacob Nevers				19 MOTHER'S NAME (First Middle Maiden Surname) Pearl Janowski			
20a INFORMANT'S NAME (Type/Print) Sheila Demkovich		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7073 Millrun Circle, Naples, FL. 34109				20c Relationship Daughter	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) March 3, 2000 Elmwood Cemetery		21c LOCATION—City or Town State Hammond, Indiana			
22a EMBALMER'S NAME Dean G. Wagner		22b EMBALMER'S LICENSE NO. 8800057		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324			
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. Bronchopneumonia Asystolic cerebral death Cardiac arrest							
26 PART II THIS CERTIFIES THE ABOVE IS A TRUE AND IMMEDIATE CAUSE OF THE CERTIFICATE OF DEATH. RETURN TO FILE WITH THE LAKE COUNTY HEALTH DEPT. Conditions if any which gave rise to the immediate cause stating the ultimate cause last MAR 07 2000							
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			
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>[Signature]</i>		29c MEDICAL LICENSE NO. IN 25043		29d DATE SIGNED (Month Day Year) 3/31/2000	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Krishnan Potti, M.D. 8300 Broadway Ave., Merrillville, In. 46410 219-769-4616							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>							
32 DATE FILED (Month Day Year) <i>March 1, 2000</i>							
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home farm street factory office building etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED 02011					
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 02011					

DECEDENT

PARENTS

INFORMANT

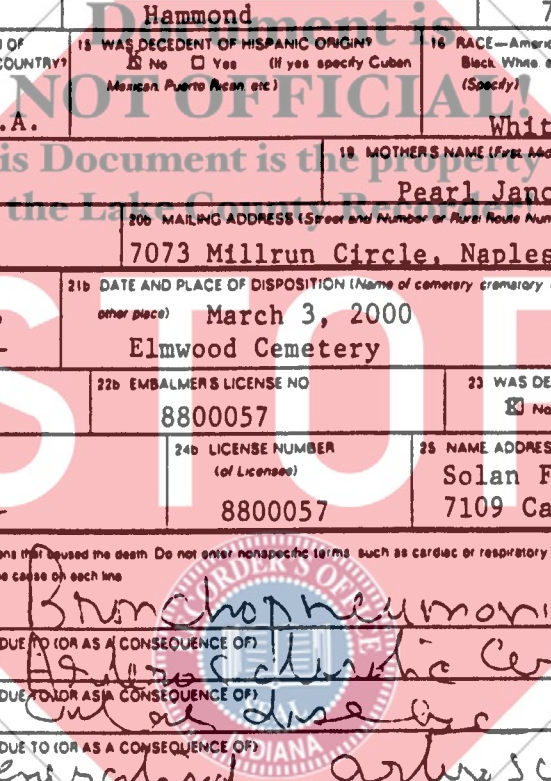
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

COMMUNITY TITLE COMPANY
FILE NO. 2 19781



FILED
STATE DEPT. OF HEALTH

AUG 25 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR/AT

02011
[Handwritten initials]