

2000-064346

Key# 15-479-53

* 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

Local No. 1139-99

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) JOHN V. DAVIES		2 SEX Male	3a TIME OF DEATH 3:15 P M	3b DATE OF DEATH (Month, Day, Yr) May 9, 1999	
4 SOCIAL SECURITY NUMBER 316-14-2460	5a AGE—Last Birthday (Years) 74	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) May 20, 1924	
7 BIRTHPLACE (City and State or Foreign Country) Aswestry, England	8a WAS DECEDENT A U.S. VETERAN? Yes				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	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 Hospital Southlake Campus		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) Irene Czerwin	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Senior Plant Assignor		12b KIND OF BUSINESS/INDUSTRY Ameritech	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 4040 W. 76th Avenue		
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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) 12		College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) Richard Davies		19 MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Lacon			
20a INFORMANT'S NAME (Type/Print) Irene Davies		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4040 W. 76th Avenue, Merrillville, Indiana 46410		20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) May 12, 1999 Calvary Cemetery		21c LOCATION—City or Town, State Portage, Indiana	
22a EMBALMER'S NAME -----		22b EMBALMER'S LICENSE NO. -----		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Alexis Chaves</i>		24b LICENSE NUMBER (of Licensee) FD08600505	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410		
26 PARTICULARS OF THE DISEASE INJURY OR COMPLICATIONS THAT CAUSED THE DEATH. Do not enter nonspecific terms such as cardiac or respiratory. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH COMMISSIONER. Acute pneumonia of lung secondary to Coronary artery disease				Approximate Interval Between Onset and Death	
Conditions if any that give rise to the multiple cause stating the underlying cause last. MAY 17 1999 <i>Alexander Stilianos MD</i>					
27a SIGNATURE AND TITLE OF HEALTH COMMISSIONER <i>Alexander Stilianos MD</i>		27b WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	27c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
28a 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) as stated.		28b SIGNATURE AND TITLE OF CERTIFIER PETER BENJAMIN LAKE COUNTY AUDITOR			
29a SIGNATURE AND TITLE OF CERTIFIER <i>Shannon McCarthy MD</i>		29b DATE SIGNED (Month, Day, Year) 01031401		29c DATE SIGNED (Month, Day, Year) 5-10-99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Shannon McCarthy, M.D., 333 W. 89th Avenue, Suite W4, Merrillville, IN 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Stilianos MD</i>					
32 DATE FILED (Month, Day, Year) May 11, 1999					
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)	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.			

C.S 9:00/AR