199006548 [illegible]

NOTICE ESTATE: The Social Security # is requested by this state agency in order to ... its statutory responsibility. Disclosure is ...ary and there will be no penalty for refusal.

... No. 2343-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	VIRGINIA PASCOE
2. SEX	F
3a. TIME OF DEATH	3:55 P.
3b. DATE OF DEATH (Month Day Yr)	10-7-99
4. SOCIAL SECURITY NUMBER	544-34-9553
5a. AGE—Last Birthday (Years)	75
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day, Yr)	3-29-24
7. BIRTHPLACE (City and State or Foreign Country)	OREGON
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN US 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)	REGENCY PLACE
9c. CITY, TOWN OR LOCATION OF DEATH	DYER
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	DIV.
11. SURVIVING SPOUSE (If wife, give maiden name)	
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	WAITRESS
12b. KIND OF BUSINESS/INDUSTRY	RESTAURANT
13a. RESIDENCE—STATE	IN.
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	WHITING
13d. STREET AND NUMBER	2623 NEW YORK
13e. ZIP CODE	46394
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)	8
College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last)	WM. H. POND
19. MOTHER'S NAME (First, Middle, Maiden Surname)	MINOLA DALEY
20a. INFORMANT'S NAME (Type/Print)	SANDI NISSEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2613 NEW YORK WHITING IN.
20c. Relationship	NIECE
21a. METHOD OF DISPOSITION	☐ Burial ☑ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	10-14-99 REGIONAL CREM. SERVICES
21c. LOCATION—City or Town, State	MUNSTER, IN.
22a. EMBALMER'S NAME	T. OWENS
22b. EMBALMER'S LICENSE NO.	1001049
23. WAS DEATH REPORTED TO CORONER?	☑ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature] Wes Owens
24b. LICENSE NUMBER (of Licensee)	1001049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	OWENS F.H. 816-119th ST WHITING, IN. 300291

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Pneumonia	
b. DUE TO (OR AS A CONSEQUENCE OF):	CHF	
c. DUE TO (OR AS A CONSEQUENCE OF):	A-Fib.	
d. DUE TO (OR AS A CONSEQUENCE OF):		

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month Day Year)
[signature] A. Stemer	01025591	10-15-1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. A. STEMER 7761 [illegible] MUNSTER, IN. 46321

31. HEALTH OFFICER'S SIGNATURE: [signature] Alexander S. Williams M.D.

32. DATE FILED (Month Day Year): October 15, 1999

33. MANNER OF DEATH	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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

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

JUN 16 2000

[signature] Alexander S. Williams M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
SEP 6 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

Key # 26-34-298-7

9.00 AR C.T.

Chicago Title Insurance Company

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STOP

RECORDER'S OFFICE SEAL INDIANA

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1