

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.
LAKE COUNTY

Local No. 04704-01

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

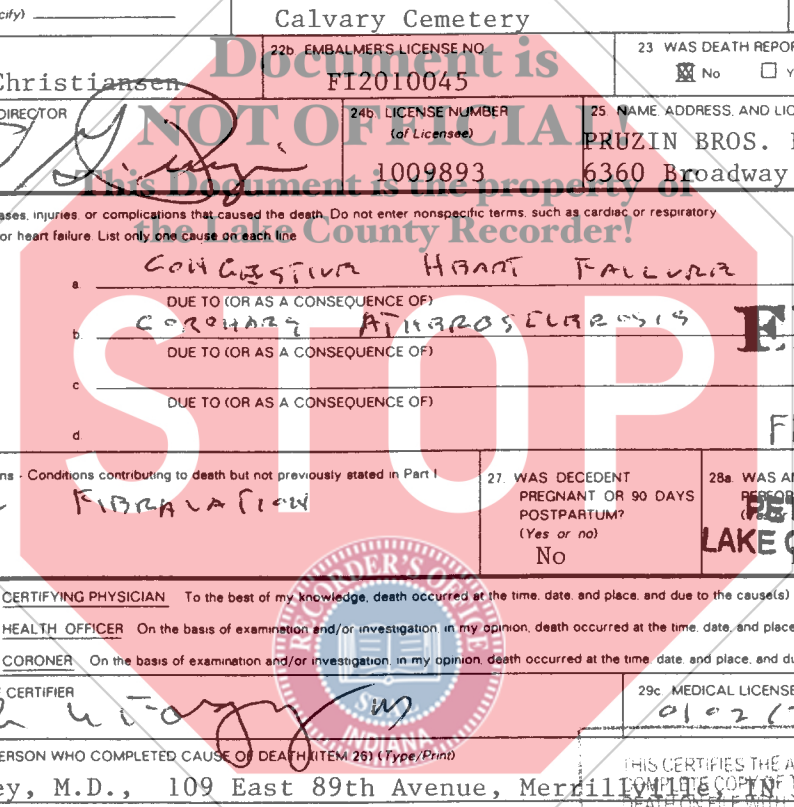
INFORMANT

DISPOSITION

1 DECEASED—NAME (First, Middle, Last) MARY SUE NEALON		2 SEX Female	3a TIME OF DEATH 2:31 P.M.	3b DATE OF DEATH (Month, Day, Yr) November 2, 2001	
4 *SOCIAL SECURITY NUMBER 303-32-0700	5a AGE (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 PLACE OF BIRTH (City and State or Foreign Country) January 14, 1932 Gary, Indiana	
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---	9a PLACE OF DEATH (Check only type. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
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) Mike J. Nealon	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Meat Wrapper		12b KIND OF BUSINESS/INDUSTRY Supermarkets	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Calumet Township	13d STREET AND NUMBER 2253 West 48th Place		
13a ZIP CODE 46408	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+) 12		18 FATHER'S NAME (First, Middle, Last) Paul Palazzolo			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Grace Casabianco		20a INFORMANT'S NAME (Type/Print) Mike J. Nealon		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2253 West 48th Place, Gary, IN 46408	
20c Relationship Husband		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) November 5, 2001 Calvary Cemetery		21c LOCATION—City or Town, State Portage, Indiana			
22a EMBALMER'S NAME Jonathon R. Christiansen		22b EMBALMER'S LICENSE NO. FI2010045		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 1009893		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410	
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 CONGESTIVE HEART FAILURE 3 4.5 hrs					
b CORONARY ARTEROSCLEROSIS 8 4.5 hrs					
c DUE TO (OR AS A CONSEQUENCE OF)					
d DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I ATRIAL FIBRILLATION					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO SIGNATURE OF CAUSE? 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. 01021236		29d DATE SIGNED (Month, Day, Year) Nov 5 2001	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) William Forgey, M.D., 109 East 89th Avenue, Merrillville, IN 46410			THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. 769-6055		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) November 5, 2001		
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 NOV 15 2001
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. 000742			

USE OF
ATH
Key # 39-301-27
Unit # 01
Orchard Hill Add to Gary
lots 27 + 28, Block 4

ALTH
FICER
[Signature]
3255 W. 48th Pl
Merrillville, IN 46408



FILED
FEB 12 2002

**PETER BENJAMIN
LAKE COUNTY AUDITOR**