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. 529-02

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Edward Nunez

2 SEX: Male

3a TIME OF DEATH: 3:10 A M

3b DATE OF DEATH (Month, Day, Yr.): March 1, 2002

4 *SOCIAL SECURITY NUMBER: 316-24-5669

5 AGE—Last Birthday (Years): 71

5a UNDER 1 YEAR: Months / Days

5c UNDER 24 HOURS: Hours / Minutes

6 DATE OF BIRTH (Mo., Day, Yr.): Oct. 10, 1930

7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana

8a WAS DECEDENT A U.S. VETERAN?: Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A

9a PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): William Riley Hospice Center

9c CITY, TOWN, OR LOCATION OF DEATH: Munster

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Virginia Corpus

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Motor Inspector

12b KIND OF BUSINESS/INDUSTRY: Steel Manufacturing

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Schererville

13d STREET AND NUMBER: 241 Little John Dr.

13e ZIP CODE: 46375

13f INSIDE CITY LIMITS? ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): Mexican

16 RACE—American Indian, Black, White, etc. (Specify): White

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 3

PARENTS

18 FATHER'S NAME (First, Middle, Last): Emilio Nunez

19 MOTHER'S NAME (First, Middle, Maiden Surname): Maria Avila

INFORMANT

20a INFORMANT'S NAME (Type/Print): Virginia Nunez

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 241 Little John Dr., Schererville, In. 46375

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 4, 2002 St. Michael Church Cemetery

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: Edgar C. Gleim

22b EMBALMER'S LICENSE NO.: FDO 1016173

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: E. C. Gleim

24b LICENSE NUMBER (of Licensee): FDO 1014511

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 19900008

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 ADVANCED PANCREATIC CANCER 3mo

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):
d

FILED

MAR 6 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

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 (Yes or no):

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) and manner 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

29c MEDICAL LICENSE NO: 01031582

29d DATE SIGNED (Month, Day, Year): 3-4-02

29b SIGNATURE AND TITLE OF CERTIFIER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): LYLE R. MANN MD 4321 FIR ST E. CHICAGO IN 46312

32 DATE FILED (Month, Day, Year): March 5, 200

31 HEALTH OFFICER'S SIGNATURE

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

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