ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 339

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

July 2, 2002 — Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	THOMAS B. CONLEY
2. Sex	MALE
3a. Time of Death	2:55 PM
3b. Date of Death (Month, Day, Yr)	MAY 6, 1995
4. *Social Security Number	311-12-3007
5a. Age—Last Birthday (Years)	72
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	NOV. 7, 1922
7. Birthplace (City and State or Foreign Country)	Lynchburg, Virginia
8a. Was Decedent a U.S. Veteran?	Yes US ARMY
8b. Year Last Served in U.S. Armed Forces?	WWII 1946
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)	Residence: 6719 Madison Avenue
9c. City, Town, or Location of Death	Hammond
9d. County of Death	Lake
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	Mabel Hedrick
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Overhead Crane Operator
12b. Kind of Business/Industry	L.T.V. Steel
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town, or Location	Hammond
13d. Street and Number	6719 Madison Avenue
13e. Zip Code	46324
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? (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) / College (1-4 or 5+)	10

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	Lewis Conley
19. Mother's Name (First, Middle, Maiden Surname)	Nannie Moore

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Mrs. Mabel E. Conley
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	6719 Madison Ave. Hammond, IN 46324
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	May 10, 1995 Chapel Lawn Memorial Gardens
21c. Location—City or Town, State	Schererville, Indiana
22a. Embalmer's Name	David McCoy
22b. Embalmer's License No.	FD08700581
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD01013507
25. Name, Address, and License Number of Funeral Home	Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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. Metastatic Carcinoma to the
DUE TO (OR AS A CONSEQUENCE OF):
b. brain & lungs
DUE TO (OR AS A CONSEQUENCE OF):
c. primary unknown
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.

Field	Entry
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

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) 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) as stated.

Field	Entry
29b. Signature and Title of Certifier	F G Pamintuan MD [signature]
29c. Medical License No.	023156
29d. Date Signed (Month, Day, Year)	May 9, 1995
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Florino F. Pamintuan, M.D. 7905 Calumet Avenue Munster, IN 46321

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	[signature] M.D.
32. Date Filed (Month, Day, Year)	MAY 10 1995

Field	Entry
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.	

000753

9.00 M.V. cash

FILED JUL 11 2002 PETER BENJAMIN LAKE COUNTY AUDITOR

0599330002 0002

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

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