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Local No. 887

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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

St July 30, 2001
Date Issued

Hammond Health Commissione

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): JOSEPH A. BENEDICT

2 SEX: MALE

3a TIME OF DEATH: 5:15P M

3b DATE OF DEATH (Month Day Yr): NOVEMBER 3,1991

4 SOCIAL SECURITY NUMBER: 309-09-2215

5a AGE—Last Birthday (Years): 77

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day. Yr): Sept.30,1914

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

8a WAS DECEDENT A US VETERAN? Yes

8b YEAR(S) SERVED IN US ARMED FORCES? 1945

2002 067261

HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA

9a PLACE OF DEATH (Check only one See instructions)
OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number): 2138 Lake 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): Anna Evano

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

12b KIND OF BUSINESS/INDUSTRY: Amoco Oil Company

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Hammond(Whiting P.O.)

13d STREET AND NUMBER: 2138 Lake Avenue

13e ZIP CODE: 46394

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)

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

17 DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Joseph Benedict

19 MOTHER'S NAME (First, Middle, Maiden Surname): Helen Tomkp

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mrs. Anna Benedict

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2138 Lake Ave., Whiting, IN 46394

20c Relationship: Wife

DISPOSITION

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

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 7,1991 St. John Cemetery

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

22a EMBALMER'S NAME: Martin A. Dybel

22b EMBALMER'S LICENSE NO: FDE01019456

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FDE01019456

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc., FDH83007267 1235-119th, Whiting, IN 46394

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 Carcinoma Colon
DUE TO (OR AS A CONSEQUENCE OF):

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

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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): 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): n/a

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) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c MEDICAL LICENSE NO: 29782

29d DATE SIGNED (Month, Day, Year): Nov. 4,1991

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M.Y. Ali, M.D., 9116 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

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

32 DATE FILED (Month, Day, Year): November 4, 1991

CORONER USE ONLY

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) C01537

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

9.00 MW

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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