INDIANA STATE BOARD OF HEALTH

Local No. 0388-92

9-18-28 (92)

HBT T1-920025925

CERTIFICATE OF DEATH

State	Nia										
State	TAO.	 		_		_					

TYPE (PRINT	1 DECEASED—NAME (First	Middle Last)				2 SEX		3a TIME OF DEATH 3b DATE OF DEATH (Month Day 17)						
TYPE/PRINT IN	MARY	E.	DU	BICH	, see	FEM	ALE	6:04P.	FEBRUA	2, 1992				
PERMANENT	4 SOCIAL SECURITY NUMBER	3 5.	a AGE—Last Birthday (Years)	Sh UNDER 1 YEAR			DATE OF BIR	RTH (Mo. Day, Yr)	7 BIRTHPLACE (City					
BLACK INK	316-03-604		75	Months Days	Hours				BEAVER DA	M,KEN	VTUCKY			
	8a. WAS DECEDENT A U.S. VETERAN?	200	AST STRUEL IN	HOSPITAL X Inpati][N 9a p	T	EATH (Check only on						
	NO	- ~ -	N/A		outpatient	ነሰሰል.	OTHER	☐ Nursing Home	Other (Specify)					
DECEDENT	9b FACILITY NAME (If not instr	tution, give st	reet and number)		otobelient ES		WHI OH LO	CANON OF DEATH	94 COUNTY OF	F DEATH				
DECEDENT	THE COM	MUNITY	HOSPITAL			MU	NSTER		L	AKE				
	10. MARITAL STATUS (Specify)	11. SUR (If w	VIVING SPOUSE fe. give maiden name)		12a. DECEDE done dur	NT'S USUAL (OCCUPATION OCCUPATION OCCUPATION OF THE PROPERTY OF THE PROPER	ON (Give kind of work not use retired)	125 KIND OF BUS	SINESS/INC	DUSTRY			
	MARRIED		ETER DUBI			HOME				HOM	E			
	13a. RESIDENCE—STATE	13b. CO		13c CITY, TOWN, OR I				13d. STREET AND N						
	INDIANA 13e. ZIP CODE 13f. INSIDE C	NTV LIMITS	LAKE	HAMMOND 15. WAS DECEDENT			728-118 E—American Indian	th Stree	17 DECEDENT'S EDUCATION					
] □ No		WHAT COUNTRY	7 X No 🗆 Y	res (If yes.	specify Cuban	Blaci	k, White, etc.			rade completed)			
	46394 139 ON A F		USA	Mexican, Puerto R	lican, etc.)			edy)	Elementary/Secondary	y (0-12)	College (1-4 or 5 +			
	18. FATHER'S NAME (First, Mid			ocum	ent	I to MOTH	1	WHITE (First Middle, Maiden	l 12					
PARENTS	WESLEY STE		/2707				ONA		Juliu in					
INFORMANT	20a. INFORMANT'S NAME (Typ		NO	20b MAILING	G ADDRESS (S				Town, State, Zip Code)	20c. Re	eletionship			
INFORMANT	JEANETTE S	IEVEI	RS.	12301	So.Eas	t 219t	h Pl.	Kent WAS	SH. 98031	DAU	JGHTER			
	219. METHOD OF DISPOSITION	N 🗆 Ente	ombment	216 DATE AND PLACE				rematory, or	21c. LOCATION—City	or Town, S	tate			
	☐ Burial ☐ Cremation		noval from State	ce other place) FE	BRUAR	Yorlde	1992		SCHERER	VTT.T.	E. INDI			
	☐ Donation ☐ Other (Sp	ecify)		CHAPEL						• • • • •				
DISPOSITION	22a EMBALMER'S NAME			225 EMBALMER'S			23	WAS DEATH REPOR	RTED TO CORONER?					
	THOS. OWEN:	_		FDE100	LU49	BEB	25 NAME		ENSE NUMBER OF FUN	JERAL HON	AF			
					(of Licensee)				AL HOME					
	Wos- (we	vs.	FD	E1001	049	816-	119th \$	t.,Whiti	ng,I	N 46394			
-	26. PART I. Enter the dis	eases, injurie	s, or complications that ca	aused the death. Do not en	iter nonspecific	terms, such as	cardiac or n	copyetory			Approximate			
	arrest, shock	c or heart fail	ure. List only one cause of					THIS CERTIFIES	IHE ABOVE IS A TRU	IF AND	Interval Between Onset and Death			
	IMMEDIATE CAUSE (Final disease or condition		· Cere	OR AS A CONSEQUENCE	CULF	n	The c	TOWN LET CODY	OF THE CERTIFICA	TEAE				
CAUSE OF	resulting in death)		Coron	SAV ~	3000	5/2	11/	CENTRADES	THE CARE COUR	N 1 .				
DEATH	Conditions, if any, which gave rise to the immediate cause.		DUE TO (OR AS A CONSEQUENC	CE OF)	1		3/100	EL	3				
	stating the underlying		DUE TO	OR AS A CONSEQUENC	CE OF)		-		7002		+			
	cause last		d				1		· ····					
	PART II. Other significant conditi	ions - Conditi	ons contributing to death	but not previously stated	n Part I.	27 WAS DEC	EDENT	284 WASI	MUTO SY 4286	WERE AUT	OPSY FINDINGS			
				but not previously stated to best of my knowledge, de-	Amin	PREGNAN	NT OR 90 (DAYS PERFOR	MED?	ALL	E PRIOR TO			
					III	(Yes or	no) N	0 (783	TEABENJA	TOPE	ves or no)			
	X							PL	COUNTY	N	/A			
	29a CERTIFIER (Check only	LUEALTH C	DEFICER On the house	best of my knowledge, dea	ath occurred at	the time, date, a	and place, an	og gne to be Whee	as stated.	as stated				
	one)	CORONER	On the basis of examin	nation and/or investigation	in my opinion.	death occurred	at the time.	date and place and di	ue to the cause(s) and ma	nner as sta	ted			
	296 SIGNATURE AND TIPLE C	OF CERTIFIER					290	MEDICAL LICENSE	NO. 29d. D	ATE SIGNI	ED (Month, Day, Year)			
CERTIFIER	1/h	gree	·).	men.	M	1		35070	F	EBRUA	RY 13,199			
	30. NAME AND ADDRESS OF			_	**									
			CH, M.D. 7	905 CALUME	T AVE.	MUNST	rer,	INDIANA 4						
HEALTH	31. HEALTH OFFICER'S SIGNA	TURE	() Volland	1/2 Tollies	الحراب المريسية المرابع	بايد			34 04	TE FILED	Month, Day, Year)			
OFFICER	33. MANNER OF DEATH		34a DATE OF INJU	RY 345 TIME OF	340.1	NJURY AT WO	ORK?	344 DESCRIBE HO	IW INJURY OCCURRED	Ur. L	<u>, 11)2 </u>			
	33. MANNER OF DEATH		(Month, Day, Ye		1	Yes or no)	JIK'	340. DESCRIBE INC		000943				
	Natural Pending	ition						,-xu						
CORONER	LI Accident			URY—At home, farm, stre-	et, factory, offic	:0	34f LOCA	TION (Street and Nur	nber or Rural Route Num	ber, City or	Town State)			
USE ONLY	Suicide Could no Determin		building, etc (S)	респу)							U.			
	349 DATE PRONOUNCED DE	AD (Moort 7) Year) 345 4407	OR VEHICLE ACCIDENT	7 (Yes or on)	If was coacid:	dever pass	egger pedestrian etc		$-\epsilon$	HH			
	Say Date FRONCONCED DE	-S (Month, L	ay. rearr 340 MOII	S VE. OCE ACCIDENT	(es or no)	yes. specify	er. pesse	gor. peursirian, ell			MIL			
											IM			
	SBH06-004 State Fo	rm 1011	0 (R2/3-89)	DEA CERT PD :							· , //			