* **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

Local No. 01 0686 State No.

#267409

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

TYPE/PRINT IN PERMANENT BLACK INK

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2002 NOV 12 AM 10:11
MORRIS W. CARTER
RECORDER

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOHN PHILLIP ADAMS
2. SEX: Male
3a. TIME OF DEATH: 5:30p.m.
3b. DATE OF DEATH (Month, Day, Yr.): October 26, 2001
4. *SOCIAL SECURITY NUMBER: 303-32-1544
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Month, Day, Yr.): Feb 6, 1933
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1950
9a. PLACE OF DEATH (Check only one. See instructions.): ☐ Hospital: Inpatient ☐ ER/Outpatient ☐ DOA ☐ Nursing Home/Long Term Care ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 4179 Georgia St.
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mary Lou Murphy
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steelworker
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: GAry
13d. STREET AND NUMBER: 4179 Georgia St.
13e. ZIP CODE: 46409
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY: USA
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): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Floyd A. Adams
19. MOTHER'S NAME (First, Middle, Maiden Surname): FRances Krantz

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mary Lou Adams
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4179 Georgia St. Gary, In 46409
20c. Relationship: Wife

DISPOSITION

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): October 31, 2001 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indian
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr.
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina Funeral HOme FH83007819 5100 Cleveland St. GAry, In 4640

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Metastatic Melanoma Extensive metastases — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: >8 yrs

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.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: S/p Immunotherapy.

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)

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] MD
29c. MEDICAL LICENSE NO.: 01035695
29d. DATE SIGNED (Month, Day, Year): 10.30.01.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. SANGHVI M.D. CANCER HEALTH ASSOCIATES 8127 MERRILLVILLE RD MERRILLVILLE IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD

FILED
DATE FILED (Month, Day, Year): OCT 31 2002

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year): NOV 18 2002
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.

PETER BENJAMIN
LAKE COUNTY AUDITOR
#3445

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

Ervin C. Carstensen