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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) **JACQUES E BERBESQUE** 2. SEX **Male** 3a. TIME OF DEATH **2:30 AM** 3b. DATE OF DEATH (Month, Day, Yr.) **May 11, 2003**

4. SOCIAL SECURITY NUMBER **315-28-8525** 5a. AGE - Last Birthday (Years) **79** 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo., Day, Yr.) **February 28, 1924** 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? **1951** PLACE OF DEATH (Check only one See instructions) HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Other (Specify) Residence

9a. FACILITY NAME (If not institution, give street and number) **VNA HORTON HOSPICE CENTER** 9c. CITY, TOWN, OR LOCATION OF DEATH **VALPARAISO** 9d. COUNTY OF DEATH **PORTER**

10. MARITAL STATUS (Specify) **Married** 11. SURVIVING SPOUSE (If wife, give maiden name) **DOROTHY EVANS** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **Maintenance** 12b. KIND OF BUSINESS/INDUSTRY **LAKE COUNTY**

13a. RESIDENCE - STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN OR LOCATION **Gary** 13d. STREET AND NUMBER **2310 WEST RIDGE ROAD**

13e. ZIP CODE **46408** 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 highest grade completed) Elementary/Secondary (0-12) **12** College (1-4 or 5+) **N/A**

18. FATHER'S NAME (First, Middle, Last) **JOHN BERBESQUE** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **HELEN**

20a. INFORMANT'S NAME (Type/Print) **DOROTHY BERBESQUE** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2310 W. RIDGE ROAD, Gary, IN 46408** 20c. Relationship **Wife**

21a. METHOD OF DISPOSITION Burial Entombment Cremation Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **May 17, 2003 Calumet Park Cemetery** 21c. LOCATION - City or Town, State **Merrillville, Indiana**

22a. EMBALMER'S NAME **CRAIG B. MALONE** 22b. EMBALMER'S LICENSE NO. **1022392** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *Terrence Burns* 24b. LICENSE NUMBER (of Licensee) **FD1013890** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **BURNS FUNERAL HOME FEB31002445 10101 Broadway, Crown Point, Indiana**

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) **PENDING FURTHER INVESTIGATION** a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. 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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) **No** 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) **Yes** 28b. WERE AUTOPSY FINDINGS CONSISTENT WITH THE MANNER OF DEATH? (Yes or no) **Yes**

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.

29b. SIGNATURE AND TITLE OF CERTIFIER *Doris A. Amling* **Deputy Coroner Porter County** 29c. MEDICAL LICENSE NO. **CORONER - 64** 29d. DATE SIGNED (Month, Day, Year) **May 19, 2003**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) **PORTER COUNTY CORONER - Doris A. Amling, 155 Indiana Avenue, Valparaiso, IN 46383**

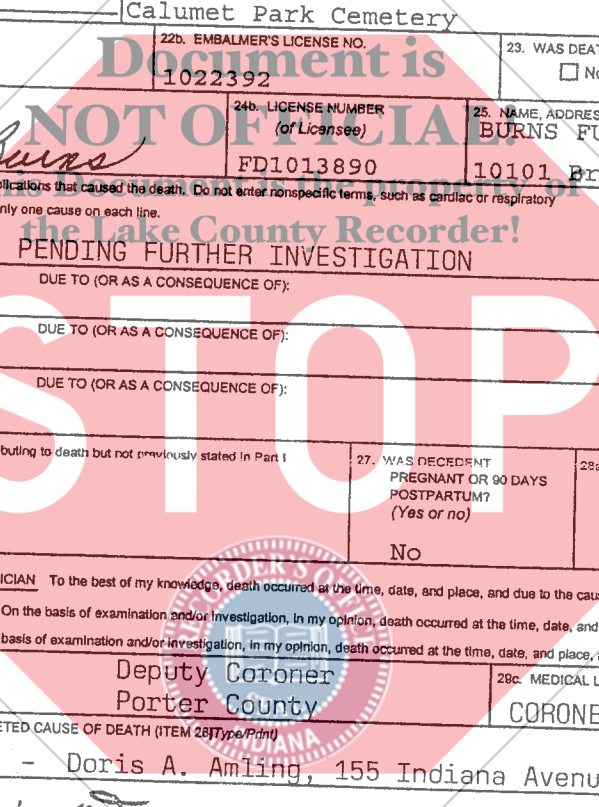
31. HEALTH OFFICER'S SIGNATURE *Harry A. Debrock MD* 32. DATE FILED (Month, Day, Year) **May 19, 2003**

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 **000619**

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) **9.00 Cash**

34g. DATE PRONOUNCED DEAD (Month, Day, Year) **May 11, 2003** 34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

ADA TACKER, 4808 RAISTON PL, GRIFFITH, IN 46319



FILED JUL 8 2003 STEPHEN R. STALLON LAKE COUNTY AUDITOR

No: 159694

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Babcock, MD
HEALTH OFFICER

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2003 JUL 08 AM 11:13
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