* **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.

Local No. 0366-97

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

44047

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Myrl	I.	Williamson	Female	09:45 PM	February 9, 1997

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Mo. Day. Yr)	7. BIRTHPLACE (City and State or Foreign Country)
308-32-4855	81					Feb 2, 1916	IN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
No	N/A		

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthony's Medical Center	Crown Point	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Bernard C. Williamson Sr	Homemaker	Own Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Lowell	19910 Colfax

13e. ZIP CODE	13f. INSIDE CITY LIMITS ☒ No ☐ Yes	13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46356			USA		White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Frank Lappie	Florence Jondrow

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Bernard C. Williamson Sr.	19910 Colfax Lowell, IN 46356	Husband

DISPOSITION

21a. METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
	February 12, 1997 Lowell Memorial Cemetery	Lowell IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
Kenneth P. Sheets	FD08900045	

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Ken Sheets	FD08900045	Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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. Acute Cerebral Infarct 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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

FEB 18 1997

FILED

Alexander S. Williams, MD

LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT WITHIN 12 MONTHS PRIOR TO DEATH? POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

OCT 15 2003

STEPHEN R. STIGLICH

LAKE COUNTY AUDITOR

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) and manner 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Bernardo S. Lucena	01039302	2/19/97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Bernardo S. Lucena MD, 1121 South Indiana, Crown Point, In. 46307

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32. DATE FILED (Month, Day, Year): February 18, 1997

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				001195

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.

9-1 DG 5612

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