* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 2469-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 15-14-10 + 11

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): RAY W MANIS
2. SEX: Male
3a. TIME OF DEATH: 8:00 AM
3b. DATE OF DEATH (Month, Day, Yr.): October 17, 2003
4. *SOCIAL SECURITY NUMBER: 307-01-5696
5a. AGE - Last Birthday (Years): 89
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): March06,1914
7. BIRTHPLACE (City and State or Foreign Country): FORBOS Tennessee
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1943
PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 5903 E. 97TH AVENUE
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): WILDA HABERKORN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): TRACTOR OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: U.S. STEEL
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 5903 E. 97TH AVENUE
13e. ZIP CODE: 46307
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): 8; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): N/A
19. MOTHER'S NAME (First, Middle, Maiden Surname): N/A

INFORMANT

20a. INFORMANT'S NAME (Type/Print): WILDA MANIS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5903 E. 97TH AVE., CROWN POINT, IN 46307
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 20, 2003 Calumet Park Cemetery
21c. LOCATION - City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: TERRENCE P. BURNS
22b. EMBALMER'S LICENSE NO.: 1013890
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P. Burns
24b. LICENSE NUMBER (of Licensee): FD1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	immediately
b. DUE TO (OR AS A CONSEQUENCE OF):	Coronary artery disease	years
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: Myelodysplastic syndrome; Urinary bladder carcinoma; Prosthetic aortic valve

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): 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: Ernest Mirich MD
29c. MEDICAL LICENSE NO.: 01018811
29d. DATE SIGNED (Month, Day, Year): 10/21/03
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. ERNEST MIRICH 9001 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. Burt D.O.
32. DATE FILED (Month, Day, Year): October 22, 2003
33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year): October 19, 2003
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

FILED OCT 22 2003 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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9.00 08 CP

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

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