

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE, COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Franklin D. ...

Local No. 433

June 5, 1997
Date Issued

Hammond Health Commission

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) Roy A. McKown				2. SEX Male		3a. TIME OF DEATH 7:35A M		3b. DATE OF DEATH (Month, Day, Year) June 4, 1997	
4. *SOCIAL SECURITY NUMBER 314-20-1108A		5a. AGE—Last Birthday (Years) 70		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) February 25 1927	
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) St. Margaret Mercy North Hospital				9c. CITY, TOWN, OR LOCATION OF DEATH Hammond				9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Joanna Barber Nowak		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Color Mixer			12b. KIND OF BUSINESS/INDUSTRY Wall Paper		
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond			13d. STREET AND NUMBER 4413 Torrence Ave		
13e. ZIP CODE 46327		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) White	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) Roy Melvin McKown					
19. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Wilk						20. INFORMANT'S NAME (Type/Print) Joanna McKown			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 Torrence Ave Hammond, IN 46327						20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) June 6, 1997 Concordia Cemetery				21c. LOCATION—City or Town, State Hammond, Indiana	
22a. EMBALMER'S NAME James Porras				22b. EMBALMER'S LICENSE NO. 1045964		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>				24b. LICENSE NUMBER (of Licensee) 1045184		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish 5840 Honman Ave Hammond, IN 46320			
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. Cellulitis mediastinum DUE TO (OR AS A CONSEQUENCE OF) b. Fem. Malory Weiss syndrome DUE TO (OR AS A CONSEQUENCE OF) c. (Rupture esophageal gastric junction) DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last 7/2004									
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		28. WAS AN AUTOPSY PERFORMED? (Yes or no) No	
						28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>John ...</i>						29c. MEDICAL LICENSE NO. 18203		29d. DATE SIGNED (Month, Day, Year) 6/4/97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Lanman, M.D., 716 Seberger Drive Munster, IN 46321									
31. HEALTH OFFICER'S SIGNATURE <i>Franklin D. ...</i>							32. DATE FILED (Month, Day, Year) June 5, 1997		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			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) 001243				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

Handwritten initials/signature