2004459BT

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. 21.2.5-01 State No. .....

28684

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

TYPE/PRINT IN PERMANENT BLACK INK

CHICAGO TITLE INSURANCE COMPANY

1 DECEASED—NAME (First, Middle, Last): DONALD KEITH MEYER			2 SEX: MALE	3a TIME OF DEATH: 8:39 P M	3b DATE OF DEATH (Month, Day, Yr.): SEPTEMBER 27, 2001
4. *SOCIAL SECURITY NUMBER: 313-54-1457	5a AGE—Last Birthday (Years): 51	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr.): OCTOBER 27, 1949	7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1971	9a 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): 7706 FOREST AVE.		9c CITY, TOWN, OR LOCATION OF DEATH: MUNSTER		9d COUNTY OF DEATH: LAKE	
10. MARITAL STATUS (Specify): MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name): MARY LOU SKAFISH	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SHEET METAL WORKER		12b KIND OF BUSINESS/INDUSTRY: STEEL	
13a RESIDENCE—STATE: INDIANA	13b COUNTY: LAKE	13c CITY, TOWN, OR LOCATION: MUNSTER		13d STREET AND NUMBER: 7706 FOREST AVE.	
13e ZIP CODE: 46321	13f INSIDE CITY LIMITS ☐ No ☒ Yes / 13g ON A FARM? ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY?: U.S.A.	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 +):
18 FATHER'S NAME (First, Middle, Last): GEORGE MEYER		19 MOTHER'S NAME (First, Middle, Maiden Surname): ELSIE COOPER			
20a INFORMANT'S NAME (Type/Print): MARY LOU MEYER		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7706 FOREST AVE. MUNSTER, IN. 46321		20c Relationship: WIFE	
21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): OCTOBER 1, 2001 NORTHWEST INDIANA CREMATION SERVICE		21c LOCATION—City or Town, State: CROWN POINT, INDIANA	
22a EMBALMER'S NAME: NOT EMBALMED		22b EMBALMER'S LICENSE NO.: N/A		23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR: Samuel Miller		24b LICENSE NUMBER (of Licensee): FD01006015		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL HOME FH83003035, 2828 HIGHWAY AVE. HIGHLAND, IN. 46322	

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Metastatic Cancer of Colon	9 mos
DUE TO (OR AS A CONSEQUENCE OF) b		
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last. 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: History of Esophageal cancer

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): -

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: Barbara Fuller, M.D.

29c MEDICAL LICENSE NO.: 01034701

29d DATE SIGNED (Month, Day, Year): 10/01/01

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BARBARA FULLER M.D. 9305 CALUMET AVE. MUNSTER, INDIANA 46321

31 HEALTH OFFICER'S SIGNATURE: Susan D Bast D.O.

32 DATE FILED (Month, Day, Year): October 1, 2001

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: 000269
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.			

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

OCT 01 2001

FILED JUN 8 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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