**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. 594-04 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First, Middle, Last): Frances D. Meyer
2 SEX: Male
3a TIME OF DEATH: 6:08 A M
3b DATE OF DEATH (Month, Day, Yr.): February 28, 2004
4 SOCIAL SECURITY NUMBER: 306-10-7911
5a AGE—Last Birthday (Years): 97
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr.): July 29, 1906
7 BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): 7807 Hohman Ave.
9c CITY, TOWN, OR LOCATION OF DEATH: Munster
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Widowed
11 SURVIVING SPOUSE (If wife, give maiden name): N/A
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Chemist
12b KIND OF BUSINESS/INDUSTRY: Pharmaceutical
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Munster
13d STREET AND NUMBER: 7807 Hohman Ave.
13e ZIP CODE: 46321
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): 12; College (1-4 or 5 +): 4

**PARENTS**

18 FATHER'S NAME (First, Middle, Last): Joseph Meyer
19 MOTHER'S NAME (First, Middle, Maiden Surname): Celia Hoedel

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Pamela Yttri
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9122 Verbena Munster, IN 46321
20c Relationship: Daughter

**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): March 3, 2004 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, IN
22a EMBALMER'S NAME: John Noble
22b EMBALMER'S LICENSE NO.: 9000031
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas Burns
24b LICENSE NUMBER (of Licensee): 5684
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3004968 8415 Calumet Ave. Munster, IN 46321



**CAUSE OF DEATH**

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter non-specific 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 Cardiomyopathy
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.

Approximate Interval Between Onset and Death



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)
28a WAS AN AUTOPSY PERFORMED? (Yes or no)
WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Susan J Burt D.O.
29c MEDICAL LICENSE NO.: 01042343
29d DATE SIGNED (Month, Day, Year): MAR 2 2004

**HEALTH OFFICER**

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. s. Patel 5500 Hohman Ave. Hammond, IN 46320
31 HEALTH OFFICER'S SIGNATURE
32 DATE FILED (Month, Day, Year): MAR 3 2004

SOUTHSHORE TITLE LLC 94004582

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34 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 (e.g., home, building, etc.) (Specify)
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)



I CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

000367

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

SDH06-004 State Form 10110 (R5/1-99)