* 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. 653

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

#35-363 24

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

Sept 23, 2004 — Date Issued

R R Kanan, MD — Hammond Health Commissioner

TYPE PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	WILLIAM T. DeDUAL SR.
2. Sex	Male
3a. Time of Death	2:55 AM
3b. Date of Death (Month, Day, Yr)	September 22, 2004
4. *Social Security Number	326-30-1164
5a. Age—Last Birthday (Years)	66
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	March 22, 1938
7. Birthplace (City and State or Foreign Country)	Chicago, Illinois
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces?	1957
9a. Place of Death (Check only one)	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. Facility Name (If not institution give street and number)	7528 Alexander
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)	Blonnie P. Norris
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Machinist
12b. Kind of Business/Industry	Aerospace
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Hammond
13d. Street and Number	7528 Alexander
13e. Zip Code	46323
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)	10

PARENTS

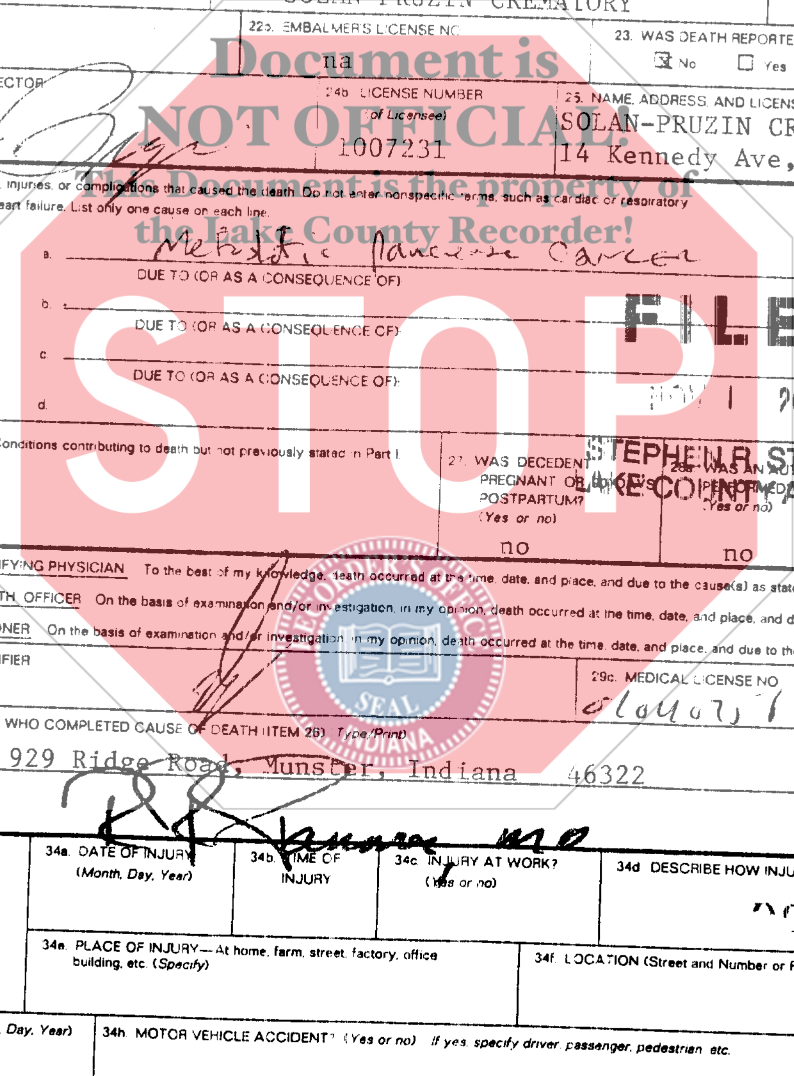
Field	Entry
18. Father's Name (First, Middle, Last)	Bernard DeDual
19. Mother's Name (First, Middle, Maiden Surname)	Edwana Lewiston

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	August DeDual
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2930 Gibson Pl, Hammond, Ind. 46323
20c. Relationship	Son

DISPOSITION

Field	Entry
21a. Method of Disposition	☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	September 24, 2004 SOLAN-PRUZIN CREMATORY
21c. Location—City or Town, State	Schererville, Indiana
22a. Embalmer's Name	na
22b. Embalmer's License No.	na
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	1007231
25. Name, Address and License Number of Funeral Home	SOLAN-PRUZIN CREMATORY #10200037 14 Kennedy Ave, Schererville, IN 46375



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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Metastatic Pancreas Cancer	1 month
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

FILED NOV 1 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

Field	Entry
27. Was Decedent Pregnant or 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)	na

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.

Field	Entry
29b. Signature and Title of Certifier	✓ [signature]
29c. Medical License No.	01041071
29d. Date Signed (Month, Day, Year)	Sept. 22, 2004
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	G. JANO M.D., 929 Ridge Road, Munster, Indiana 46322

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	R R Kanan MD
32. Date Filed (Month, Day, Year)	September 23 2004

Field	Entry
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)	
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

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