* **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. 491

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

#32177-49

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

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

Jul, 27, 2004 — Date Issued

R R Kovacs, M.D. — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): THOMAS M. BEAN				2. SEX: Male	3a. TIME OF DEATH: 4:50 AM M
3b. DATE OF DEATH (Month, Day, Yr.): July 24, 2004					
4. *SOCIAL SECURITY NUMBER: 414-16-1547	5a. AGE—Last Birthday (Years): 87	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.): September 12, 1916	7. BIRTHPLACE (City and State or Foreign Country): BRINKIN, TN
8a. WAS DECEDENT A U.S. VETERAN?: YES	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): 915 LOGAN STREET	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): EULA WRIGHT	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor at Sewer Dept.	12b. KIND OF BUSINESS/INDUSTRY: City of Hammond
13a. RESIDENCE—STATE: INDIANA	13b. COUNTY: LAKE	13c. CITY, TOWN, OR LOCATION: HAMMOND	13d. STREET AND NUMBER: 915 LOGAN STREET

13e. ZIP CODE: 46320	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): 4 — College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ALVIS BEAN	19. MOTHER'S NAME (First, Middle, Maiden Surname): MAE (unavailable)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): EULA MAE BEAN	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 915 LOGAN STREET, HAMMOND, IN 46320	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☒ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jul 28, 2004 LYNCHBURG CEMETERY	21c. LOCATION—City or Town, State: LYNCHBURG TN
22a. EMBALMER'S NAME: JOSE G. CORONA	22b. EMBALMER'S LICENSE NO.: FDO8601373	23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John Ault	24b. LICENSE NUMBER (of Licensee): FDO1013507	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BOCKEN FUNERAL HOME, INC. FH83002801, 7042 KENEDY AVENUE, HAMMOND, IN

CAUSE OF DEATH

28. 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. Congestive Heart failure	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia	
	c. DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary disease	
	d. DUE TO (OR AS A CONSEQUENCE OF): Fracture Left Hip	

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	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: Sirajuddin Khaja	29c. MEDICAL LICENSE NO: 01032657A	29d. DATE SIGNED (Month, Day, Year): 7-26-04 (July)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SIRAJUDDIN KHAJA, M.D. 921 FRANKLIN PARKWAY, MUNSTER, IN 46321-

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: R R Kovacs, M.D. FILED

32. DATE FILED (Month, Day, Year): July 27, 2004

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 Ooccurred
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.			

NOV 1 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

000102

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