

ATTENTION ESTATE: Disclosure of the facts we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 2878-94

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <i>Jane Duan Watt</i>				2. SEX <i>Female</i>		3a. TIME OF DEATH <i>1:31P.</i>		3b. DATE OF DEATH (Month, Day, Yr) <i>November 5, 1994</i>							
4. *SOCIAL SECURITY NUMBER <i>314-18-3575</i>		5a. AGE—Last Birthday (Years) <i>73</i>		5b. UNDER 1 YEAR Months: Days:		5c. UNDER 1 DAY Hours: Minutes:		6. DATE OF BIRTH (Mo, Day, Yr) <i>May 22, 1921</i>		7. BIRTHPLACE (City and State or Foreign Country) <i>Cedar Lake, Indiana</i>					
8a. WAS DECEDENT A U.S. VETERAN? <i>No</i>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" 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) <i>St. Margaret Mercy Hospital</i>				9c. CITY, TOWN, OR LOCATION OF DEATH <i>Dyer</i>		9d. COUNTY OF DEATH <i>Lake</i>	
10. MARITAL STATUS (Specify) <i>Married</i>		11. SURVIVING SPOUSE (If wife, give maiden name) <i>James Watt</i>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <i>Secretary</i>				12b. KIND OF BUSINESS/INDUSTRY <i>Government Office</i>							
13a. RESIDENCE—STATE <i>Indiana</i>		13b. COUNTY <i>Lake</i>		13c. CITY, TOWN OR LOCATION <i>St. John</i>		13d. STREET AND NUMBER <i>10911 West 108th Street</i>									
13e. ZIP CODE <i>46373</i>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		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) <i>White</i>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): <i>12</i> College (1-4 or 5+): <i>2</i>					
18. FATHER'S NAME (First, Middle, Last) <i>Monte Biesecker</i>						19. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ila Glen Brannock</i>									
20a. INFORMANT'S NAME (Type/Print) <i>James Watt</i>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10911 W. 108 St. St. John, Indiana 46373</i>				20c. Relationship <i>Husband</i>							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) <i>November 8, 1994 German Methodist Cemetery</i>				21c. LOCATION—City or Town, State <i>Cedar Lake, Indiana</i>							
22a. EMBALMER'S NAME <i>Fred Oparka</i>				22b. EMBALMER'S LICENSE NO. <i>FD01016076</i>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes									
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Fred Oparka</i>				24b. LICENSE NUMBER (of Licensed) <i>FD01016076</i>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <i>Eller Brady Funeral Home, Inc. FH83000825 Cedar Lake, Indiana 46303</i>									
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Massive blunt force injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>															
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Alcohol consumption</i>															
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <i>No</i>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <i>Yes</i>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <i>Yes</i>											
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> DEPUTY 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 <i>Kathy Philpot</i>						29c. MEDICAL LICENSE NO. <i>N/A</i>		29d. DATE SIGNED (Month, Day, Year) <i>November 9, 1994</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <i>Kathy Philpot, Deputy Coroner, 2293 North Main Street, CrownPoint, Indiana 46307</i>															
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams MD</i>								32. DATE FILED (Month, Day, Year) <i>November 9, 1994</i>							
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) <i>Nov. 5, 1994</i>		34b. TIME OF INJURY <i>Unknown</i>		34c. INJURY/AT WORK? (Yes or no) <i>NO</i>		34d. DESCRIBE HOW INJURY OCCURRED <i>Auto./Pick-up Truck</i>							
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) <i>Highway</i>						34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>9200 block of U.S. 41 St. John, Indiana</i>									
34g. DATE PRONOUNCED DEAD (Month, Day, Year) <i>November 5, 1994</i>				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <i>Yes Driver</i>											