Local No. 303

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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

State Sept. 21, 2006 — Date Issued — Hammond Health Commissioner

26-36-0292-0637

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (FIRST, MIDDLE, LAST): Russell C. Lewallen
2. SEX: Male
3. DATE OF DEATH (Mo, Day, Yr): March 31, 1988
4. SOCIAL SECURITY NUMBER: 314-05-8128
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): October 6, 1912
7. BIRTHPLACE (City and State or Foreign Country):
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: No
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 7618 Jackson
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Margaret Caldwell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Melter Foreman
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel Comapny
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7618 Jackson
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46324
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Charles Lewallen
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Overstreet

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Margaret Lewallen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7618 Jackson Hammond, Indiana 46324
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Chapel Lawn Memorial Gardens April 4, 1988
20c. LOCATION—City or Town, State: Schererville, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): FDE1018769
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: C.J. Huber Funeral Home 722 165th Street Hammond Indiana 46324 FDH3002851

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER:
23c. DATE SIGNED (Month, Day, Year):

ITEMS 24-26 MUST BE COMMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 2:17 P.M.
25. DATE PRONOUNCED DEAD (Month, Day, Year): March 31, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

CAUSE OF DEATH — SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardio Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Ventricular Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
c. Aspiration Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
d. Advanced Parkinson's Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

CERTIFIER — SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: X [signature]
29c. LICENSE NUMBER: X 0101932
29d. DATE SIGNED (Month, Day, Year): X 4/4/88 (APRIL 4, 1988)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Carlos Serna, M.D. 2342 Ridge Road Highland, Indiana 46322

HEALTH OFFICER

FILED

31. HEALTH OFFICER SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): APR 05 1988

CORONER OR MEDICAL EXAMINER USE ONLY

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:
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):

FILED SEP 21 2006
19514
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

2006 061638 (stamp)

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11.00
DIL-M.

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD 1