

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.

Local No. 565

Nov. 13, 2007  
Date Issued  
Hammond Health Commissioner

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

CORONER  
USE ONLY

1. DECEASED—NAME (First, Middle, Last) <b>Bernice M. Johnson</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>11:30 p.m.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>July 19, 1991</b>	
4. SOCIAL SECURITY NUMBER <b>009-48-4002</b>	5a. AGE—Last Birthday (Years) <b>85</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>March 24, 1906</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Snyder, Indiana</b>		8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input 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) <b>St. Margaret Hospital</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Hammond</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Housewife</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Hammond</b>	13d. STREET AND NUMBER <b>2830 Janet Place</b>		
13e. ZIP CODE <b>46323</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8<sup>3</sup></b>		18. FATHER'S NAME (First, Middle, Last) <b>Iva Norman Luchine</b>			
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Peterson</b>		20a. INFORMANT'S NAME (Type/Print) <b>Mr. Jack D. Johnson</b>			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2830 Janet Pl., Hammond, IN 46323</b>		20c. Relationship <b>Son</b>			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>July 23, 1991 Oakland Memory Lanes</b>		21c. LOCATION—City or Town, State <b>Delton, Illinois</b>	
22a. EMBALMER'S NAME <b>Charles D. Scheuer, Jr.</b>		22b. EMBALMER'S LICENSE NO. <b>1006049</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John V. Huber</i>		24b. LICENSE NUMBER (of License) <b>1045362</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Virgil Huber Funeral Home — 3002869 7051 Kennedy, Hammond, IN 46323</b>		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>a. Cardiac arrest</b> <b>b. Ventricular fibrillation</b> <b>c. Atherosclerotic heart disease</b> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <b>d.</b>					
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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>		
29a. CERTIFIER (Check only one) <input checked="" 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 type="checkbox"/> 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 <i>John C. Mason M.D.</i>			29c. MEDICAL LICENSE NO. <b>17753</b>	29d. DATE SIGNED (Month, Day, Year) <b>July 23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>J. C. Mason, M.D. 7905 Calumet Avenue, Munster, Indiana 46321</b>					
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Demuda M.D.</i>				32. DATE FILED (Month, Day, Year) <b>July 23, 1991</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) <b>FILED</b>	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) <b>024191</b>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR</b>			
COMMUNITY TITLE COMPANY FILE NO. <b>38806</b>					