

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2899-93

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

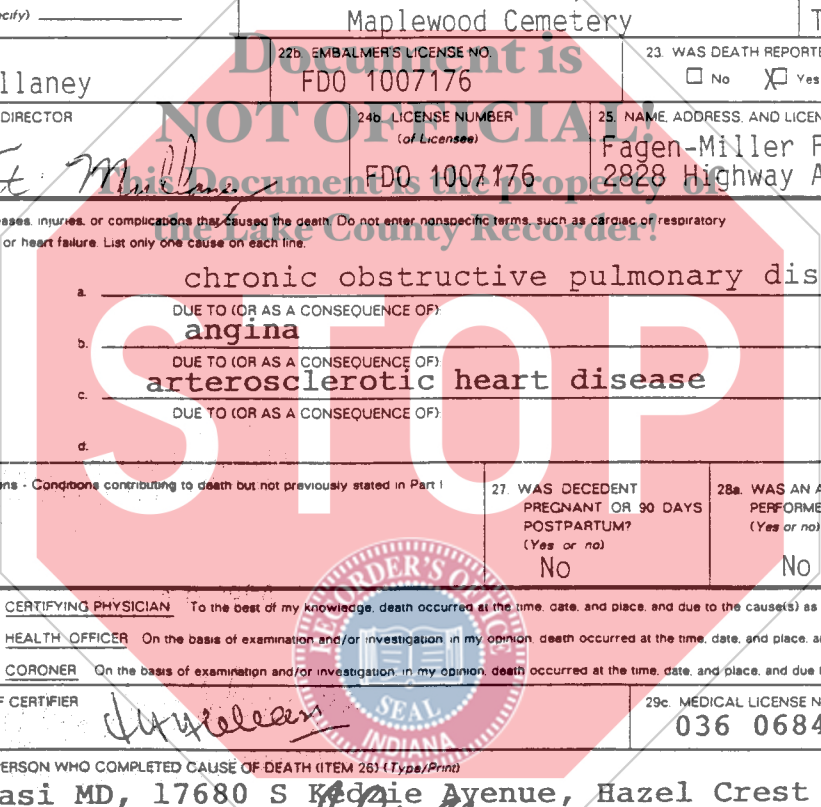
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Raymond Ashley Darnell		2 SEX Male	3a TIME OF DEATH 1:55 P M	3b DATE OF DEATH (Month, Day, Year) December 18, 1993
4 SOCIAL SECURITY NUMBER 410-26-4494		5a AGE—Last Birthday (Years) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo, Day, Yr) September 5, 1921		7 BIRTHPLACE (City and State or Foreign Country) Normandy, Tennessee		
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LEFT SERVED IN U.S. ARMED FORCES? 2008-04-26-71	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA: <input type="checkbox"/> Residence <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) St Margaret Mercy Hospital-South		9c CITY, TOWN, OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Dorothy Mae Reed	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Ironworker	12b KIND OF BUSINESS/INDUSTRY Local Union	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Schererville	13d STREET AND NUMBER 497 Kennedy Ave	
13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> 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+)		18 FATHER'S NAME (First, Middle, Last) Robert Lee Darnell		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Dora Bell O'Kelly		20a INFORMANT'S NAME (Type/Print) Dorothy Mae Darnell		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 497 Kennedy Ave. Schererville, IN. 46375		20c Relationship Wife		
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) December 22, 1993 Maplewood Cemetery		21c LOCATION—City or Town, State Tullahoma, Tennessee
22a EMBALMER'S NAME Edward F. Mullaney		22b EMBALMER'S LICENSE NO. FDO 1007176	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>		24b LICENSE NUMBER (of Licensee) FDO 1007176	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH8300303 Fagen-Miller Funeral Gardens Inc 2828 Highway Ave Highland, IN. 46375	
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) a. chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): b. angina DUE TO (OR AS A CONSEQUENCE OF): c. arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): d. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last				Approximate Interval Between Onset and Death
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)
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>Alexander D. Williams</i>			29c. MEDICAL LICENSE NO. 036 068401	29d. DATE SIGNED (Month, Day, Year) December 20, 1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) T. Abbasi MD, 17680 S Kedzie Avenue, Hazel Crest IL 60429				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams M.D.</i>				32. DATE FILED (Month, Day, Year) December 21, 1993
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input 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)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. HOW INJURY OCCURRED		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		



FILED
JUN - 9 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR
009553