INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 586-08 BT800652 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
DELBERT L. CREVISTON		M	12:44 PM	FEBRUARY 18, 2008

5. Social Security Number	6a. Age Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
[redacted]-2548	85	Months	Days	Hours	Minutes	December 12, 1922	HAMMOND, INDIANA

9. Ever In U.S. Armed Forces?	10. If Death Occurred In A Hospital:	10a. If Death Occurred Somewhere Other Than A Hospital:
☒ Yes ☐ No Unknown ☐	☐ Inpatient ☒ Emergency Department Outpatient ☐ Dead On Arrival	☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): COMMUNITY HOSPITAL

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
MUNSTER, INDIANA 46321	LAKE	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
NONE	N/A	PIPEFITTER	CONSTRUCTION

18. Residence – State	18a. County	18b. City Or Town	18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
INDIANA	LAKE	GRIFFITH	317 WEST 44TH PLACE		46319	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
High school graduate or GED completed	No, not Spanish/Hispanic/Latino	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
ISAAC CREVISTON	UNAVAILABLE	N/A

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
RONALD CREVISTON	SON	626 NORTH ELMER APT. D, GRIFFITH, IN 46319 AFFiant

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, INDIANA

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322	FH1[illegible]002

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee)
David A Peter	FD08601585

FILED
SEP 04 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

			Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A.	cardiac arrythmia	
Due To (Or As A Consequence Of):			
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last	B.	coronary artery disease	
Due To (Or As A Consequence Of):			
	C	chronic obstructive pumonary disease	
Due To (Or As A Consequence Of):			
	D.		

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
X Yes ☐ Probably ☐ No ☐ Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street And Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: [signature] DO — FEB 19 2008

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: William Cataldi DO 840 Richard Rd Dyer IN 46311

44. License Number: 02000476

45. Date Certified: 011937

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: Susan W Burt D.O.

49. For Registrar Only – Date Filed (Month/Day/Year): February 19, 2008

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10