

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 168

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) JAMES J. WARD		2. SEX MALE		3a. TIME OF DEATH 11:28A M		3b. DATE OF DEATH (Month, Day, Yr.) FEBRUARY 28, 2003	
4. *SOCIAL SECURITY NUMBER 303-36-4856		5a. AGE—Last Birthday (Years) 66		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) AUG. 4, 1936		7. BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA					
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN ARMED SERVICES 2008 N/A		8c. HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9a. PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) 2016 ATCHISON AVENUE				9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) CAROL LAWRENCE		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) MACHINIST		12b. KIND OF BUSINESS/INDUSTRY BLAW-KNOX	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HAMMOND (WHITING P.O.)		13d. STREET AND NUMBER 2016 ATCHISON AVENUE	
13e. ZIP CODE 46394		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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) WHITE		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2					
18. FATHER'S NAME (First, Middle, Last) BERNARD WARD				19. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET KANYUR			
20a. INFORMANT'S NAME (Type/Print) MRS. CAROL WARD		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 ATCHISON, WHITING, IN 46394				20c. Relationship WIFE	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) MARCH 3, 2003 ST. JOHN CEMETERY				21c. LOCATION—City or Town, State HAMMOND, INDIANA	
22a. EMBALMER'S NAME HENRY J. BLAKE		22b. EMBALMER'S LICENSE NO. FDE01019406		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Walter A. [Signature]</i>		24b. LICENSE NUMBER (of Licensee) FDE01019456		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394			
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. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Vascular collapse					Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. Due to arteriosclerotic heart and vascular disease					
		c. DUE TO (OR AS A CONSEQUENCE OF)					
		d. DUE TO (OR AS A CONSEQUENCE OF)					
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) N/A		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
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 checked="" 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. Chief 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) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) March 3, 2003
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Ellettsville, Indiana 46307							
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. [Signature]</i>						32. DATE FILED (Month, Day, Year) March 3, 2003	
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. DESCRIBE HOW INJURY OCCURRED PELGY HOLINGA KATONA	
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)				34f. LOCATION (City and County, Rural Route Number, City or Town, State) LAKE COUNTY, INDIANA			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 019221 # 3550					

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER