* 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.

Local No. 2961-00

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. DECEASED—NAME (First, Middle, Last)	HAROLD WARREN DOOLEY
2. SEX	MALE
3a. TIME OF DEATH	4:05 A.M.
3b. DATE OF DEATH (Month, Day, Yr.)	DECEMBER 19, 2000
4. *SOCIAL SECURITY NUMBER	[redacted]
5a. AGE—Last Birthday (Years)	81
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	DEC. 7, 1919
7. BIRTHPLACE (City and State or Foreign Country)	HARRISBURG, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?	YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1943
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)	THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH	MUNSTER
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	MAGDALEN KAMINSKY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	BUYER
12b. KIND OF BUSINESS/INDUSTRY	AMOCO OIL COMPANY
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HAMMOND
13d. STREET AND NUMBER	3720 GROVER AVENUE
13e. ZIP CODE	46327
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5 +)	

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	JESSE DOOLEY
19. MOTHER'S NAME (First, Middle, Maiden Surname)	LUCILLE CRAILEY

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	MRS. MAGDALEN DOOLEY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3720 GROVER AVE., HAMMOND, IN 46327
20c. Relationship	WIFE

DISPOSITION

Field	Value
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	DECEMBER 22, 2000 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State	HAMMOND, INDIANA
22a. EMBALMER'S NAME	MARTIN A. DYBEL
22b. EMBALMER'S LICENSE NO.	FDE01019456
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Martin A. Dybel
24b. LICENSE NUMBER (of Licensee)	FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BARAN & SON, INC., FDH83007267 1235-119TH ST., WHITING, IN 46394

2009 061628

CAUSE OF DEATH

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Respiratory failure	12 hours
b. DUE TO (OR AS A CONSEQUENCE OF)	pneumonia	
c. DUE TO (OR AS A CONSEQUENCE OF)	aspiration	
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Coronary artery disease; Myocardial infarction

Field	Value
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)	N/A

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

2009 SEP 22 PM 3:33

MICHAEL A. BROWN RECORDER

CERTIFIER

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ 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.

☐ 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.

Field	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	M Martini MD
29c. MEDICAL LICENSE NO.	01046113
29d. DATE SIGNED (Month, Day, Year)	DECEMBER 20, 2000
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	MOHAMAD MARTINI, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321

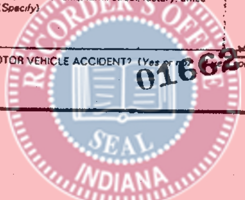
HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	[signature] MD
32. DATE FILED (Month, Day, Year)	Dec 26, 2000
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)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

$11 CS CK

FILED SEP 22 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

01662



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