ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to ...ue its statutory responsibility. Disclosure is ...ntary and there will be no penalty for refusal.

...cal No. 1595-03

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

CERTIFIED as a true and exact copy of this original document.
State No.
Community Title Co.

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

TYPE/PRINT IN PERMANENT BLACK INK

Field	Entry
1 DECEASED—NAME (First Middle Last)	Glenn E. McGhee
2 SEX	Male
3a TIME OF DEATH	02:30 AM
3b DATE OF DEATH (Month Day Yr)	November 2, 2003
4 *SOCIAL SECURITY NUMBER	[redacted]
5a AGE—Last Birthday (Years)	87
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	May 3, 1916
7 BIRTHPLACE (City and State or Foreign Country)	Woodburn Iowa
8a WAS DECEDENT A U.S. VETERAN?	No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
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)	Lowell Healthcare Center
9c CITY, TOWN OR LOCATION OF DEATH	Lowell
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Wilma Carter
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Mechanic
12b KIND OF BUSINESS/INDUSTRY	John Deere
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Lowell
13d STREET AND NUMBER	7314 S. Willowbrook Dr.
13e ZIP CODE	46356
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	Caucasian
17 DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+):
18 FATHER'S NAME (First, Middle, Last)	Jimmie Y. McGhee
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Mary F. Austin
20a INFORMANT'S NAME (Type/Print)	Wilma McGhee
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7314 S. Willowbrook Dr., Lowell, IN 46356
Relationship	Wife
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	Nov 5, 2003 West Creek Cemetery
21c LOCATION—City or Town, State	Lowell IN
22a EMBALMER'S NAME	Molly E. Hawkins
22b EMBALMER'S LICENSE NO	FD09200061
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	FD09200061
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Sheets Funeral Home FH83004837, 604 E. Commercial Ave. Lowell, IN 46356

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.	Renal Failure	years
DUE TO (OR AS A CONSEQUENCE OF) b.		
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

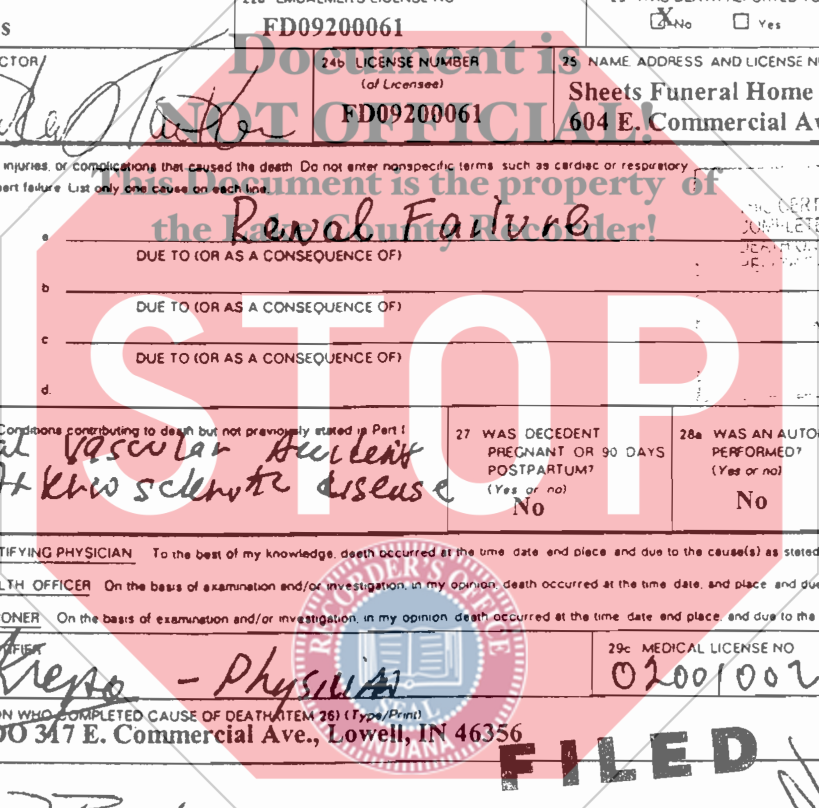
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I: s/p cerebral vascular accident; Diffuse arteriosclerotic disease

Field	Entry
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)	No
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.
29b SIGNATURE AND TITLE OF CERTIFIER	[signature] - Physician
29c MEDICAL LICENSE NO	01001002
29d DATE SIGNED (Month, Day, Year)	11/3/03
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Richard Krejsa DO 317 E. Commercial Ave., Lowell, IN 46356
31 HEALTH OFFICER'S SIGNATURE	[signature] D.O.
32 DATE FILED (Month, Day, Year)	November 5, 2003
33 MANNER OF DEATH	☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.	

SDH06-004 State Form 10110 (R5/1-99)

054771



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LAKE COUNTY AUDITOR
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