







# INDIANA STATE DEPARTMENT OF HEALTH TRACKING NUMBER 10349 CERTIFICATE OF DEATH

Local No 000224

EDR No 000011229814

State No 2022-002865

1. Decedent's Legal Name (First, Middle, Last) <b>Jerry J. Parker</b>		1a. Maiden Name (if female)		2. Gender <b>Male</b>	3. Time of Death <b>02:30 PM</b>	4. Date of Death (Month/Day/Year) <b>01/16/2022</b>	
5. Social Security Number	6a. Age - Yrs <b>79</b>	6b. Under 1 Year Months Days	6c. Under 1 Month Hours Minutes	6d. Under 1 Day Hours Minutes	7. Date of Birth (Month/Day/Year) <b>12/08/1942</b>		8. Birthplace (City and State or Foreign Country) <b>Hammond, Indiana</b>
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred in a Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival		10a. If Death Occurred Somewhere Other Than a Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street and Number) <b>Community Hospital Munster</b>							
12. City or Town, State, and Zip Code <b>Munster, Indiana 46321</b>				13. County of Death <b>Lake</b>		14. Marital Status At Time of Death <input type="checkbox"/> Married <input type="checkbox"/> Married But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name <b>Debra M. Parker</b>		15a. Last Name Before First Marriage <b>McClelland</b>		16. Decedent's Usual Occupation <b>operator</b>		17. Kind of Business/Industry <b>heavy equipment</b>	
18. Residence - State <b>IN</b>		18a. County <b>Lake</b>		18b. City or Town <b>Hammond</b>			
18c. Street and Number <b>8828 Leland Avenue</b>		18d. Apt. No.		18e. Zip Code <b>46323</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education <b>High School graduate or GED completed</b>		20. Decedent of Hispanic Origin <input type="checkbox"/> Not Spanish/Hispanic/Latino		21. Decedent's Race <b>White</b>			
22. Parents Name (First, Middle, Last) <b>Ernest Parker</b>				23. Parent's Name (First, Middle, Last) <b>Lottie Parker</b>		23a. Parent's Last Name (Before First Marriage) <b>Nowakowski</b>	
24. Informant's Name <b>Debra M. Parker</b>		24a. Relationship to Decedent <b>Wife</b>		24b. Mailing Address (Street and Number, City, State, Zip Code) <b>8828 Leland Avenue, Hammond, IN, 46323</b>			
25. Place of Disposition <b>Regional Cremation Service</b>							
25a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Corion <input type="checkbox"/> Entombment <input type="checkbox"/> Natural Fym State <input type="checkbox"/> Other (Specify)		25b. Place of Disposition (Name of Cemetery, Crematory, Other Place) <b>Regional Cremation Service</b>		25c. Location - City, Town, and State <b>Munster, IN</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name and Complete Address of Funeral Facility <b>Baran &amp; Son Inc 1235 119th Street, Whiting, Indiana, 46394</b>		27a. Funeral Home License Number <b>FH8307267</b>			
27b. Signature Of Indiana Funeral Service Licensee: <b>Martha A. Dybel</b>		27c. License Number (Of Licensee) <b>FD01019456</b>					
Part I. Enter the Cause of Death - 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 Line A. Add Additional Lines If Necessary. Immediate Cause (Final Disease or Condition Resulting In Death) A. <b>cardiac arrest</b> <span style="float: right;">5 min</span> B. <b>Respiratory failure</b> <span style="float: right;">15 min</span> C. <b>Covid pneumonia</b> <span style="float: right;">1 week</span> D. 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							
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given in Part I							
91. Use Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		92. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, but Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, but Pregnant Within The Past Year		93. Manner of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Unknown If Program Within The Past Year <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		94. Date of Injury (Month/Day/Year)	
95. Location Of Injury - State		95a. City or Town		95b. Street & Number		95c. Apt. No.	
96. Describe How Injury Occurred		96a. City or Town		96b. Street & Number		96c. Apt. No.	
97. Location Of Injury - State		97a. City or Town		97b. Street & Number		97c. Apt. No.	
98. Date of Injury (Month/Day/Year)		98a. City or Town		98b. Street & Number		98c. Apt. No.	
99. Location Of Injury - State		99a. City or Town		99b. Street & Number		99c. Apt. No.	
41. Signature of Person Certifying Cause of Death <b>Omair Saied</b>		41a. Name, Address and Zip Code of Person Certifying Cause of Death <b>Omair Saied 901 MacArthur Blvd, Munster, IN 46321</b>		42. Certifier (Check Only/Check All) <input checked="" type="checkbox"/> Carrying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		43. License Number <b>010604080A</b>	
44. Signature of Local Health Officer <b>Chandana Mysala</b>		44a. Name, Address and Zip Code of Local Health Officer		45. Date Certified <b>01/18/2022</b>		46. Additional Funeral Service Provider	
47. Signature of Local Health Officer		47a. Name, Address and Zip Code of Local Health Officer		48. For Registrar Only - Day Filed (Month/Day/Year) <b>01/16/2022</b>		49. Date of Death	

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

NOT VALID UNLESS