HO 450 274 LD (1)

INDIANA STATE BOARD OF HEALTH

Local No. 808-90 187518 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK.

DECEDENT

1. DECEASED—NAME (First, Middle, Last): NELDA ELEST RIFE
2. SEX: FEMALE
3a. TIME OF DEATH: 5:20P M
3b. DATE OF DEATH (Month, Day, Yr): APRIL 8, 1990
4. SOCIAL SECURITY NUMBER: 307-40-6217
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): SEP. 25, 1910
7. BIRTHPLACE (City and State or Foreign Country): DOWNING, MISSOURI
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: ----------
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): DIVORCED
11. SURVIVING SPOUSE (If wife, give maiden name): ----------
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): NURSE
12b. KIND OF BUSINESS/INDUSTRY: HOSPITAL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 1748 E. 34th AVENUE.
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS?: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] 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): 12 — College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): CHARLES LEWIS
19. MOTHER'S NAME (First, Middle, Maiden Surname): PEARL McCULLOUGH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CAROL MORRISON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 400 HUBERT BLVD. HOBART, IN. 46342
20c. Relationship: DAUGHTER

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 12, 1990 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: KEITH A. DILLON
22b. EMBALMER'S LICENSE NO.: FD0101205G
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: THIS CERTIFIES THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
24b. LICENSE NUMBER (of Licensee): FD0101205G
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: GEISEN FUNERAL HOME, INC. - FH83007762, 7905 BROADWAY MERRILLVILLE, IN. 46410

CAUSE OF DEATH

26. Enter the chain of events—diseases, injuries, or complications—that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. Leave blank. Type one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. APR 1 1990 — DUE TO (OR AS A CONSEQUENCE OF): b. — DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: a. ---- b. ---- c. ----

Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last.

LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT, OR IN 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

CERTIFIER

29a. CERTIFIER (Check only one): [XX] 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: Donald M. Phillips M.D.
29c. MEDICAL LICENSE NO.: 0102046
29d. DATE SIGNED (Month, Day, Year): 4/10/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DONALD PHILLIPS M.D. 1350 S. LAKE STREET HOBART, INDIANA 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Carl Johnson FHO
32. DATE FILED (Month, Day, Year): April 10, 1990

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY (Month, Day, Year): NOV 30 1990
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.: Duane A. Watson AUDITOR LAKE COUNTY.

001531

SBH06-004 State Form-10110 (R2/3-89) DEA CERT/PD