051260 92069335

Local No. 184-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST MIDDLE LAST: DIANE RIGGSBY
2 SEX: Female
3 DATE OF DEATH (Mo Day Yr): January 13, 1989
4 SOCIAL SECURITY NUMBER: 303-48-4018
5a AGE—Last Birthday (Years): 40
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Month Day Year): 9-1-1948
7 BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8 YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home XX Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): 221 WEST 8TH STREET
9c CITY TOWN OR LOCATION OF DEATH: HOBART
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): JAMES RIGGSBY
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b KIND OF BUSINESS/INDUSTRY: NONE
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 221 WEST 8TH STREET
13e INSIDE CITY LIMITS? (Yes or no): YES
13f FARM: NO
13g ZIP CODE: 46342
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican etc.) ☒ No ☐ Yes Specify
15 RACE—American Indian, Black, White etc (Specify): WHITE
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+): 1

PARENTS

17 FATHER'S NAME (First Middle Last): ROBERT H. PHILLIPS
18 MOTHER'S NAME (First Middle Maiden Surname): GERALDINE SULLENS

INFORMANT

19a INFORMANT'S NAME (Type/Print): JAMES RIGGSBY
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 221 WEST 8TH STREET, HOBART, IN 46342
19c Relationship: SPOUSE

DISPOSITION

20a METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): January 16, 1989 CHAPEL LAWN MEMORIAL GARDENS
20c LOCATION—City or Town, State: SCHERERVILLE, INDIANA
21a SIGNATURE OF FUNERAL DIRECTOR: Gerald Roes
21b LICENSE NUMBER (of Licensee): FDF1041083
22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME-FDH3003069 600 W. OLD RIDGE RD., HOBART, IN 4634

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge death occurred at the time, date, and place stated. Signature and Title
23b LICENSE NUMBER
23c DATE SIGNED (Month Day Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 8:30A M
25 DATE PRONOUNCED DEAD (Month Day Year): JANUARY 13, 1989
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): YES

SEE INSTRUCTIONS

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Malignant Neoplasm [illegible]
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF)
DUE TO (OR AS A CONSEQUENCE OF)
DUE TO (OR AS A CONSEQUENCE OF)
Approximate Interval Between Onset and Death: 18 months

CAUSE OF DEATH

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I
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

CERTIFIER

29a CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner as stated
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated
29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c LICENSE NUMBER: 3654487
29d DATE SIGNED (Month Day Year): 1-16-89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): LEONARD L. CERULLO MD, 428 WEST DEMING, CHICAGO, IL 60614

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Paul A Johnson MD
32 DATE FILED (Month Day Year): JAN 31, 89

CORONER OR MEDICAL EXAMINER USE ONLY

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)

18-250-7 Lake Pk Manor L. 7

5cc'd

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. AUG 8 1989 LAKE COUNTY HEALTH CO

FILED OCT 29 1992 Anna N. Anton AUDITOR LAKE COUNTY

FILED FOR RECORD 92 OCT 15 PM 12:... 1992 OCT 15 AM 10:56

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