7cc's

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 2530-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): MARILYN SUE THIEL
2. SEX: Female
3a. TIME OF DEATH: 1:25PM
3b. DATE OF DEATH (Month Day Yr): November 6, 1995
4. SOCIAL SECURITY NUMBER: 317-36-9891
5a. AGE - Last Birthday (Years): 58
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo Day Yr): Feb 19, 1937
7. BIRTHPLACE (City and State or Foreign Country): Gary, IN
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): 323 N. DELAWARE STREET
9c. CITY TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): ROBERT K. THIEL
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: HOME
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 323 N. DELAWARE STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): JOHN KORHEL
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET SOVICH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): ROBERT K. THIEL
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 N. DELAWARE STREET, Hobart, IN 46342
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NOV 9, 1995 EVERGREEN MEMORIAL PARK
21c. LOCATION - City or Town State: HOBART, IN
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FDO1006463
22c. WAS DEATH REPORTED TO CORONER? ☒ Yes
22d. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: [illegible] Funeral Home, [illegible] W. Old Ridge Road, Hobart, IN 46342
23a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
23b. LICENSE NUMBER (of Licensee): FDO1006463

CAUSE OF DEATH

PART I. 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. List only one cause on each line.

I HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH OFFICER.

a. Carcinomatosis of the breast — DUE TO (OR AS A CONSEQUENCE OF):
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):

Interval Between Onset and Death: Unknown

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

24. WAS DECEDENT PREGNANT OR IN 90 DAYS POSTPARTUM? (Yes or no): No
25a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

25a. 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.

Deputy

25b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
25c. MEDICAL LICENSE NO: N/A
25d. DATE SIGNED (Month Day Year): November 9, 1995

26. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print): Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32. DATE FILED (Month Day Year): November 9, 1995

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): November 6, 1995
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

#18-236-11

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SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1