

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

INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 44

CERTIFICATE OF DEATH

Date Issued Jan 16, 1997 Franklin D. Remuda, M.D.
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First Middle Last) NELLIE E. MERRILL		2 SEX FEMALE	3a TIME OF DEATH 7:40 PM	3b DATE OF DEATH (Month Day Yr) JANUARY 14, 1997
4 *SOCIAL SECURITY NUMBER 309-58-5471	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) MARCH 25, 1909
7 BIRTHPLACE (City and State or Foreign Country) LEADWOOD, MISSOURI	8a WAS DECEDENT A U.S. VETERAN? no	8b YEAR LAST SERVED IN U.S. ARMED FORCES? no	9a PLACE OF DEATH (Check only one. See instructions). HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)	
9b FACILITY NAME (If not institution give street and number) Residence: 6814 Schneider Avenue		9c CITY TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife give maiden name) none	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 Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6814 Schneider Avenue
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (1-12) 10 College (1-6 or 8+)		18 FATHER'S NAME (First Middle Last) Fred Worth		
19 MOTHER'S NAME (First Middle Maiden Surname) Susie Ann Sepaugh		20a INFORMANT'S NAME (Type/Print) Mrs. Jean C. Johnston		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6814 Schneider Avenue Hammond, IN 46323		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 17, 1997 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME David McCoy		22b EMBALMER'S LICENSE NO. FDO8700581		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO1013507		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. 83002801 7042 Kennedy Ave. Hammond, IN 46323
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. Coronary heart failure.				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) Coronary heart failure.				
DUE TO (OR AS A CONSEQUENCE OF)				
CONDITIONS if any which gave rise to the immediate cause stating the cause last				
DUE TO (OR AS A CONSEQUENCE OF)				
DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions Conditions contributing to death but not previously stated in Part I FEB 21 1997		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no		28a WAS AN AUTOPSY PERFORMED? (Yes or no) no
29a CERTIFIER (Check only) SAMORLICH AUDITOR LAKE COUNTY		To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated.		
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Rohant		29c MEDICAL LICENSE NO. 01035958		29d DATE SIGNED (Month Day Year) Jan. 16, 1997
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ravi S. Bhagwat, M.D., 9122 Columbia Avenue Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> Franklin D. Remuda, M.D.				32 DATE FILED (Month Day Year) January 16, 1997
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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)		34g DATE PRONOUNCED DEAD (Month Day Year)		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.				

Key # 33-152-748

FILED

STATE OF INDIANA
LAKE COUNTY
REC'D
97
NO RECORD

90
1/13