[redacted]

15cc LTIC 62796

* **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

CERTIFICATE OF DEATH

Local No. 0227-97 .... State No. ....

119103

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CHRISTINE PHILLIPS	2. SEX: Female	3a. TIME OF DEATH: 11:30PM	3b. DATE OF DEATH (Month, Day, Yr): January 27, 1997
4. SOCIAL SECURITY NUMBER: 313-52-7093	5a. AGE—Last Birthday (Years): 83	5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes):	6. DATE OF BIRTH (Mo, Day, Yr): September 27, 1913
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN?: NO	8b. YEAR LAST SERVED IN US ARMED FORCES?: ----	9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 3000 W. 57th Avenue	9c. CITY, TOWN OR LOCATION OF DEATH: Merrillville	9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Widowed	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): Homemaker	12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN OR LOCATION: Merrillville	13d. STREET AND NUMBER: 3000 W. 57th Avenue
13e. ZIP CODE: 46410	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): 10; College (1-4 or 5+):		

PARENTS

18. FATHER'S NAME (First, Middle, Last): Nicholas Koleff	19. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Semonova

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dr. Donald M. Phillips, M.D.	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 E. 173rd, Lowell, IN 46356	20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 30, 1997 Calumet Park Cemetery	21c. LOCATION—City or Town, State: Merrillville, Indian
22a. EMBALMER'S NAME: --------N/A----	22b. EMBALMER'S LICENSE NO: ----N/A------	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FD08600505	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762, 7905 Broadway, Merrillville, IN 46410

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Carcinoma of pancreas — [illegible]

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

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

27. WAS DECEDENT PREGNANT OR 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): ---

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

JAN 30 1997

[signature], M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
APR 17 1997
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER

29a. 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. MEDICAL LICENSE NO: 01020846	29d. DATE SIGNED (Month, Day, Year): January 29, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Donald M. Phillips, M.D., 1356 South Lake Park Ave., Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], MD	32. DATE FILED (Month, Day, Year): January 30, 1997

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):	
34g. DATE PRONOUNCED DEAD (Month, Day, Year):	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1