* 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.

Local No. 0960-98

264041

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last): DIANE E. HAMMERS
2. SEX: FEMALE
3a. TIME OF DEATH: 7:45 AM
3b. DATE OF DEATH (Month, Day, Yr): APRIL 23, 1998
4. *SOCIAL SECURITY NUMBER: 313-36-4350
5a. AGE—Last Birthday (Years): 61
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MARCH 5, 1937
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
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: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John D. Hammers
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Secretary
12b. KIND OF BUSINESS/INDUSTRY: Ennis Mortgage
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 7028 Monroe Avenue
13e. ZIP CODE: 46324
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+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): George Hatrak
19. MOTHER'S NAME (First, Middle, Maiden Surname): Jewell Bourne

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mr. John D. Hammers
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7028 Monroe Ave. Hammond, IN 46324
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 25, 1998 Memory Lane Memorial Park
21c. LOCATION—City or Town, State: Schererville, IN
22a. EMBALMER'S NAME: C. William McCoy
22b. EMBALMER'S LICENSE NO.: FD01013612
23. WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01013507
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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. Metastatic Cancer 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): 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 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): [X] 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]
29c. MEDICAL LICENSE NO.: 01027970
29d. DATE SIGNED (Month, Day, Year): APRIL 23, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SALMAN GAILANI, M.D. 9116 COLUMBIA AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): April 24, 1998
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):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

APR 29 1998 002025

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

George Zachau Park Add
unit #26
Key #36-465-1

98 APR 29 PM 2:05 STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

98030586

SAM ORLICH RECORDER

c/s good

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