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

Local No. 2689-95

Key # 47-35-19

3cc's

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 9602933

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
BONNIE LUCILE DAVIES	Female	7:24AM	November 27, 1995

4. SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr)	7. BIRTHPLACE (City and State or Foreign Country)
411-34-0086	73			Oct 2, 1922	DYERSBURG, TN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES	9a. PLACE OF DEATH (Check only one. See Instructions)
No	N/A	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. MARY MEDICAL CENTER	Hobart	Lake

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS INDUSTRY
Married	JAMES C. DAVIES	CAFETERIA	U.S. STEEL

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	LAKE	Gary	3856 JEFFERSON STREET

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE - American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46408	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	WHITE	Elementary/Secondary (0-12): 9	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARLES FORTNER	EVA BARNHILL

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
HOMER LEE FORTNER	2146 KENNEDY STREET, Portage, IN 46368	Son

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION (City or Town, State)
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Nov 29, 1995 CALUMET PARK CEMETERY	Merrillville,

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES J. KRAUSE	FDO1006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FDO1006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road Hobart, IN 46342

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. Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF)
b. Cardiac Arrhythmia.

DUE TO (OR AS A CONSEQUENCE OF)
c. Congestive Heart failure

DUE TO (OR AS A CONSEQUENCE OF)
d. Please hold with secondary

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)	AUTOPSY PERFORMED? (Yes or no)	AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
	D0134231	11-28-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
B. CHHABRA MD, 6375 U.S HWY. 6, PORTAGE, IN 46368

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams MD

32. DATE FILED (Month Day Year): November 28, 1995

33. MANNER OF DEATH	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	000368

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

900 CB

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1