Key No. 14-19-6043-0005

• **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. *1688-99*

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Elizabeth Green
2 SEX	Female
3a TIME OF DEATH	9:25 PM
3b DATE OF DEATH (Month Day Yr)	July 16, 1999
4 SOCIAL SECURITY NUMBER	305-30-2543
5a AGE—Last Birthday (Years)	76
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	January 21, 1923
7 BIRTHPLACE (City and State or Foreign Country)	Crossgar North Ireland
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1945
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)	St. Mary Medical Center
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)	Raymond B. Green
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	At Home
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Lake Station
13d STREET AND NUMBER	2040 Vermillion
13e ZIP CODE	46405
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+): 3

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Edward Nixon
19 MOTHER'S NAME (First Middle Maiden Surname)	Mary Ann Shields

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Raymond B. Green
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2040 Vermillion, Lake Station, IN 46405
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	July 20, 1999 CALVARY CEMETERY
21c LOCATION—City or Town, State	Portage, Indiana
22a EMBALMER'S NAME	Gordon L. Jones
22b EMBALMER'S LICENSE NO	01010711
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	*Gordon L. Jones*
24b LICENSE NUMBER (of Licensee)	FD01010711
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home FH83002380, 701 E. 7th Street, Hobart, Indiana 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. *Hepatic Encephalopathy*

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

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

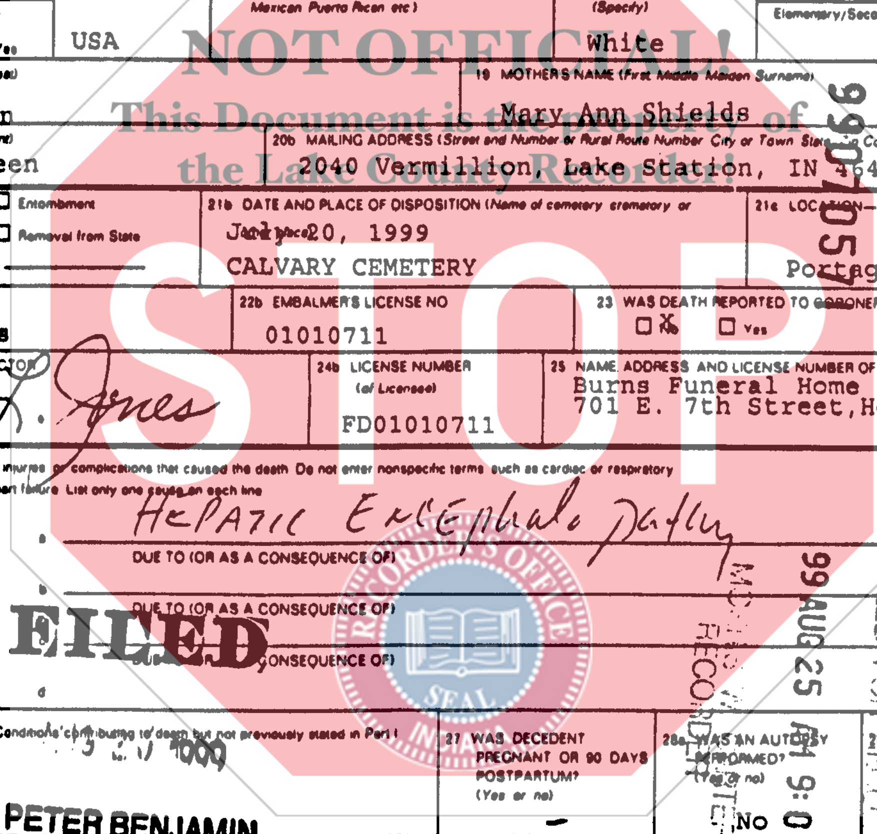
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF): d.

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): —

28a WAS AN AUTOPSY PERFORMED? (Yes or no): No

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):



FILED

PETER BENJAMIN
LAKE COUNTY AUDITOR

99 AUG 25 AM 9:0

STATE OF ... LAKE CO... FILED FOR ...

MORRIS W. CARTER RECORDER

9907051

CERTIFIER

29a CERTIFIER (Check only one):
☐ ATTENDING 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	*[signature]*
29c MEDICAL LICENSE NO	01037515
29d DATE SIGNED (Month Day Year)	7-20-99
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Milton Gasparis, M.D. 1400 S. Lake Park Avenue, Suite 301, Hobart, IN

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	*Alexander S. Williams M.D.*
32 DATE FILED (Month Day Year)	*7/21/99*
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)	July 16, 1999
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.	

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

JUL 21 1999

00305

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

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

901 / 10 / 05

25 × 10