

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

INDIANA STATE DEPARTMENT OF HEALTH

Richard Conci
 → 1916 S. Park Ave
 Schererville Ind
 46371

Local No. 0296-95

CERTIFICATE OF DEATH

State No. LAKE COUNTY

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

TYPE/PRINT
 IN
 PERMANENT
 BLACK INK

1 DECEASED—NAME (First Middle Last) Natalie Conciardi		2 SEX Female		3a TIME OF DEATH 2:50 AM	3b DATE OF DEATH (Month Day Year) February 7, 1995
4 *SOCIAL SECURITY NUMBER 99081904		5a AGE—Last Birthday (Years) 32	5b LENGTH OF RESIDENCE IN INDIANA (Months) 99 Oct	5c UNDER 18 DATE OF BIRTH (Mo Day Yr) Aug. 9, 1962	7 BIRTHPLACE (City and State or Foreign Country) Martinez, California
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9 HOSPITAL (If inpatient) W. CARTER ER Outpatient RECORDED		10 PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> Nursing home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution give street and number) Regency Place Nursing Home			9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Richard Conciardi	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most or working life. Do not use retired) Home Maker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Griffith	13d STREET AND NUMBER 201 N. Woodlawn		
13e ZIP CODE 46319	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary-Secondary (10-12) College (14 or 16)
18 FATHER'S NAME (First Middle Last) Joe Hamilton			19 MOTHER'S NAME (First Middle Maiden Surname) Alice Rodriguez		
20a INFORMANT'S NAME (Type/Print) Richard Conciardi		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 N. Woodlawn Griffith, Indiana		20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <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) February 10, 1995 Memory Lane Cemetery		21c LOCATION—City or Town, State Schererville, Indiana	
22a EMBALMER'S NAME David Peterson		22b EMBALMER'S LICENSE NO. FDO 8601585		23 WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd Highland, Indiana FH83007500	

DECEDENT

PARENTS
 INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER
 HEALTH OFFICER

Woodlawn Add kot13
 Key# 26-165-13
 unit# 15

26 PART I Enter the disease, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
 a. Cerebral anoxia
 DUE TO (OR AS A CONSEQUENCE OF)

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

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)

WHO CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
 [Signature]
 OCT 05 1999

29a CERTIFIER (Check only one)
 CERTIFYING PHYSICIAN To PETER BENJAMIN at the time, date and place and due to the cause(s) as stated
 HEALTH OFFICER On LAKE COUNTY AUDITOR
 CORNER 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

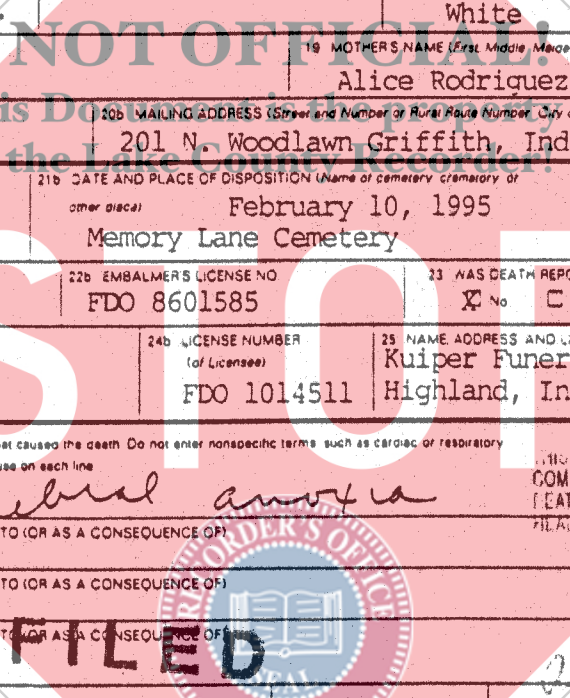
29b SIGNATURE AND TITLE OF CERTIFIER
A. Stamer
 29c MEDICAL LICENSE NO. 01025591
 29d DATE SIGNED (Month Day Year) 2-8-95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
 Alexander Stamer 1105 1/2 N. Street Munster IN 46321

31 HEALTH OFFICER'S SIGNATURE
Alexander D. Williams, M.D.
 32 DATE FILED (Month Day Year) February 8, 1995

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.



000374

9/25/95