SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 0203-00

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

15-210-3

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)	Rosemary M Saxton
2. SEX	Female
3a. TIME OF DEATH	9:45 AM
3b. DATE OF DEATH (Month, Day, Yr.)	January 20, 2000
4. *SOCIAL SECURITY NUMBER	314-01-0729
5a. AGE - Last Birthday (Years)	80
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo., Day, Yr.)	September 08,1919
7. BIRTHPLACE (City and State or Foreign Country)	Gary Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	----
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)	W. J. Riley Memorial Residence
9c. CITY, TOWN, OR LOCATION OF DEATH	Munster
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Widowed
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	Volunteer
12b. KIND OF BUSINESS/INDUSTRY	Hospital
13a. RESIDENCE - STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Merrillville
13d. STREET AND NUMBER	1016 E. 63rd
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? (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)	N/A
College (1-4 or 5+)	4

2000 006354

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Samuel J Murphy
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Rosalie Heslin

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Michael J Saxton
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1620 Pole Line Rd., Davis, CA 95616
20c. Relationship	Son

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)	January 25, 2000 N.W. Ind. Cremation Services
21c. LOCATION — City or Town, State	Crown Point, Indiana
22a. EMBALMER'S NAME	—
22b. EMBALMER'S LICENSE NO.	—
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James E Burns [signature]
24b. LICENSE NUMBER (of Licensee)	FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns Funeral Home FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2000 JAN 28 AM 11:4? MORRIS W. CARTER RECORDER

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Carcinomatosis	1 year
DUE TO (OR AS A CONSEQUENCE OF): b.	Endometrial Adenocar[illegible]	1 year
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

FILED JAN 28 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

Field	Entry
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I	Ventricular Septal Defect
27. WAS DECEDENT PREGNANT OR 90 DAYS PRIOR TO DEATH?	N
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	John T. Scully DO [signature]
29c. MEDICAL LICENSE NO.	010176?1
29d. DATE SIGNED (Month, Day, Year)	29 Jan 00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. John T. Scully, M.D. 8895 Broadway, Merrillville, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S Williams MD [signature]
32. DATE FILED (Month, Day, Year)	January 25 2000

Field	Entry
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)	January 20, 2000
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.	

FILED LAKE COUNTY HEALTH DEPT. JAN 25 2000

9.00 E.P.

Alexander S Williams MD [signature] LAKE COUNTY HEALTH COMMISSIONER

JERRY + KATHLEEN ERNY
9204 E. 93RD AVE. CROWN POINT, IN 46307

State Form 10110 (R4/2-93) Deathcer/PD 1

25 x 10 3