

* ATTENTION STATE: 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.

STATE OF INDIANA
INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 872 2000 007797
THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

2000 FEB -3 AM 9:13

NOV. 6, 1998
Date Issued
Hammond Health Commission

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First Middle Last) Anna A Brownnewell		2 SEX Female	3a TIME OF DEATH 9:50 p.m.	3b DATE OF DEATH (Month Day Yr) November 5, 1998
4 *SOCIAL SECURITY NUMBER 316-18-6487	5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) MAR. 4, 1923
7 BIRTHPLACE (City and State or Foreign Country) Indianapolis, Indiana	8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution give street and number) St. Margaret Mercy Health Care - North		9c CITY, TOWN OR LOCATION OF DEATH Hammond	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) Home Maker	12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION HAMMOND	13d. STREET AND NUMBER 7037 Chestnut Ave.	
13e. ZIP CODE 46324	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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (1-4 or 5+) 12	18. FATHER'S NAME (First Middle Last) Richard Conyers		19. MOTHER'S NAME (First Middle Maiden Surname) Jenny Sharp	
20a. INFORMANT'S NAME (Type/Print) JUDY NISEVICH		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7037 Chestnut Ave. Hammond, Indiana		20c. Relationship Daughter
21a. METHOD OF DISPOSITION <input checked="" 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) November 9, 1998 Elmwood Cemetery		21c. LOCATION—City or Town, State Hammond, Indiana
22a. EMBALMER'S NAME Edgar Gleim		22b. EMBALMER'S LICENSE NO. FDO 1016173	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Carma Slacanian</i>		24b. LICENSE NUMBER (of Licensee) FDO 1010850	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500	
28. 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) End Stage Renal disease				
DUPLICATE TO (OR AS A CONSEQUENCE OF) Uncontrolled diabetes mellitus 2000				
CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST Cerebro pulmonary apnea				
DUPLICATE TO (OR AS A CONSEQUENCE OF) PETER BENJAMIN LAKE COUNTY AUDITOR				
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
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>			29c. MEDICAL LICENSE NO. 31739	29d. DATE SIGNED (Month Day Year) November 6, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) S. Sharma, M. D. 57 Clinton Street Hammond, Indiana 46327				
31. HEALTH OFFICER'S SIGNATURE <i>Franklin S. Sremuda M.D.</i>				32. DATE FILED (Month Day Year) November 6, 1998
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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 00184		
		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) 9.00 P.P. T.		
34g. DATE PRONOUNCED DEAD (Month Day Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian, etc		