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* **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. 0 584-00

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

4-90-17

State No. .....

119353

TYPE/PRINT IN PERMANENT BLACK INK

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

STATE OF INDIANA LAKE COUNTY FILED MAR 9 39

DECEDENT

1 DECEASED—NAME (First, Middle, Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Lorraine	M.	Rattray	Female	10:15A	March 5, 2000

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)
337-16-5150	80			Apr 5, 1919	Bedford Park, IL

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
Lutheran Retirement Home	Crown Point	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	William C. Rattray	Homemaker	Own Home

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
IN	Lake	Lowell	453 Meadow Ln.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1 4 or 5 +)
46356	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Frank Bonick	Edith Rich

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
William C. Rattray	453 Meadow Ln. Lowell, IN 46356	Husband

DISPOSITION

2000 017414

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)	March 7, 2000 Heritage Crematory	Portage, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Not applicable	N/A	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD08900045	Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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 Sepsis	Days
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF)	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d 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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Chronic Obstructive Lung Disease, Post-op Cholecystectomy, Congestive Heart Failure	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)
[signature] - Physician	02001002	3-6-00

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Richard Krejsa DO, 8560 S. Broadway, Merrillville, IN 46410

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Alexander S. Williams III, M.D.	March 7 2000

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

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)
	MAR 07 2000 9:00 am cash

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	3.10.3 Alexander S. Williams III, M.D. LAKE COUNTY HEALTH COMMISSIONER

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