Local No. 1394-90

INDIANA STATE BOARD OF HEALTH

STATE OF INDIANA
LAKE COUNTY
FILED

CERTIFICATE OF DEATH

State No. 020849

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
LEANNE PHILLIPS	FEMALE	6:48 P M	JULY 2, 1990

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)
308-64-9982	35			DEC. 21, 1954	GARY, INDIANA

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 XX 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
ST. MARY MEDICAL CENTER	HOBART	LAKE COUNTY

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
WIDOWED	N/A	ASST TO THE DIRECTOR	YMCA--INDIANAPOLIS

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HOBART	123 NORTH PENNSYLVANIA

13e ZIP CODE	13f INSIDE CITY LIMITS	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN?	16 RACE—American Indian Black White etc	17 DECEDENT S EDUCATION (Specify only highest grade completed)	
	☐ No XX Yes		XX No ☐ Yes (If yes specify Cuban Mexican Puerto Rican etc)	(Specify)	Elementary Secondary (0-12)	College (1 4 or 5 +)
46342	13g ON A FARM? XX No ☐ Yes	USA		WHITE		1

PARENTS

18 FATHERS NAME (First Middle Last)	19 MOTHERS NAME (First Middle Maiden Surname)
HAROLD E. PHILLIPS	MARY L. GREEN

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
HAROLD E. PHILLIPS	123 NORTH PENNSYLVANIA, HOBART, IN 46342	FATHER

DISPOSITION

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 XX Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	JULY 5, 1990 CALVARY CREMATORY	PORTAGE, INDIANA

22a EMBALMERS NAME	22b EMBALMERS LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FD01004194	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	REES FUNERAL HOMES, INC. FDH3003069 600 W. RIDGE RD, HOBART, IN 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 Acute Respiratory Distress Syndrome -
DUE TO (OR AS A CONSEQUENCE OF)
b Sepsis.
Conditions if any which gave rise to the immediate cause stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
c pneumonitis with pericarditis.
DUE TO (OR AS A CONSEQUENCE OF)
d

MAR 13 1990

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)
	NO	N/A

FILED
MAR 2nd 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

CERTIFIER

29a CERTIFIER (Check only one)
XX 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)
Mark O Carter MD	0103-6415	7/3/90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print)
MARK O. CARTER, MD, 295 SOUTH WISCONSIN ST., HOBART, IN 46342

HEALTH OFFICER

31 HEALTH OFFICERS SIGNATURE

32 DATE FILED (Month Day Year) JUL 3, 90

CORONER USE ONLY

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)
	q.c.e.r.

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

SBH06-004 State Form 10110 (R2/3-89) DEA CERT PD 1