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

Local No. 2681-99

282363

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

STATE OF INDIANA

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED–NAME (First Middle Last): HAROLD E. PHILLIPS
2. SEX: Male
3a. TIME OF DEATH: 10:10PM
3b. DATE OF DEATH (Month Day Yr): November 23, 1999
4. SOCIAL SECURITY NUMBER: 324-03-1153
5a. AGE - Last Birthday (Years): 79
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): September 28, 1920
7. BIRTHPLACE (City and State or Foreign Country): Valparaiso, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1945
9a. PLACE OF DEATH (Check only one See instructions): [X] Hospital Inpatient; [ ] ER/Outpatient; [ ] DOA; [ ] Other: Nursing Home; [ ] Other (Specify); [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Route Supervisor
12b. KIND OF BUSINESS INDUSTRY: Cleaning
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 123 N Pennsylvania Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] 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 (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Clark A. Phillips
19. MOTHER'S NAME (First, Middle, Maiden Surname): Christine Murphy

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Patricia K. Daman
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 708 Countrywood Drive, Franklin, TN 37064
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): November 29, 1999 Calvary Crematory
21c. LOCATION - City or Town State: Portage, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, 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 respi... 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.	Cardio-respiratory Arrest	20 Minutes
DUE TO (OR AS A CONSEQUENCE OF) b.	Pneumonia Right Lower Lobe	8 Days
DUE TO (OR AS A CONSEQUENCE OF) c.	Renal Failure	1 Year
DUE TO (OR AS A CONSEQUENCE OF) d.	Hypertension, Atrial Fibrillation	5 Years

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Anemia of Chronic Disease

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

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: 01031797
29d. DATE SIGNED (Month Day Year): November 24, 1999

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): Shashikant R. Rane MD, 10 N. Michigan Avenue, Hobart, IN 46342
31. HEALTH OFFICER'S SIGNATURE: Alexander D. Hillman, M.D
32. DATE FILED (Month Day Year): November 29, 1999

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY (Month Day Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED: COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT
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): NOV 29 1999
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc: Alexander D. Hillman, M.D

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