8 cd's Re-Submit

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

Local No. 66-43-00

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. 18-25-2

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED - NAME (First, Middle, Last): Jule A Mebert
2 SEX: Female
3a TIME OF DEATH: 2:15 PM
3b DATE OF DEATH (Month, Day, Yr.): March 11, 2000
4 *SOCIAL SECURITY NUMBER: 303-32-0692
5a AGE - Last Birthday (Years): 68
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo., Day, Yr.): March 24,1931
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 ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital - South Lake Campus
9c CITY, TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Eugene Mebert
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Respiratory Therapist
12b KIND OF BUSINESS/INDUSTRY: Methodist Hospital -
13a RESIDENCE - STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hobart
13d STREET AND NUMBER: 211 S. Colorado Street
13e ZIP CODE: 46342-
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ 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+): N/A

PARENTS

18 FATHER'S NAME (First, Middle, Last): August Victor Carlson
19 MOTHER'S NAME (First, Middle, Maiden Surname): Julia Amanda Mears

INFORMANT

20a INFORMANT'S NAME (Type/Print): Eugene Mebert
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 211 S. Colorado Street, Hobart, IN 46342
20c. Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 15, 2000 Calumet Park Cemetery
21c LOCATION - City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Russell A. Kraft, Jr.
22b EMBALMER'S LICENSE NO.: 29300105
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b LICENSE NUMBER (of Licensee): FD01009461
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Acute MI
DUE TO (OR AS A CONSEQUENCE OF) b. ?IDDM Uncontrolled
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

Approximate Interval Between Onset and Death

PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y/N or U)
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT
MAR 17 2000
Alexander S. Williams MD
LAKE CO. INTY HEALTH COMMISSIONER

FILED
MAR 2 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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 ☐ 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: [signature] M.D.
29c MEDICAL LICENSE NO.: 010-35650
29d DATE SIGNED (Month, Day, Year): 3/17/00
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Suresh Reddy M.D. 751 E. 81st Place, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32 DATE FILED (Month, Day, Year): March 17, 2000

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): March 11, 2000
34h MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

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

25 x 10