

5 CCS

Key No: 41-49-42-31 Key No: 394257

FILED

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH STATE OF INDIANA State No. APR. 17. 2000

Local No. 0570-97

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First Middle Last) LEONA EVANS		2. SEX Female		3a. TIME OF DEATH 9:41		3b. PLACE OF DEATH (Check only one See instructions) LAKE COUNTY AUDITOR	
4. *SOCIAL SECURITY NUMBER 316-24-9579		5a. AGE—Last Birthday (Years) 74		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6a. WAS DECEDENT A U.S. VETERAN? NO		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		6c. PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Southlake Nursing & Rehab Center			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) James Fred Evans		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hobart		13d. STREET AND NUMBER 4034 Willow St.	
13e. ZIP CODE 46342		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc)	
16. FATHER'S NAME (First Middle Last) Jess Warren		17. MOTHER'S NAME (First Middle Maiden Surname) Daisy Bunn		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 2	
20a. INFORMANT'S NAME (Type/Print) James Fred Evans			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4034 Willow St., Hobart, IN 46342			20c. Relationship Husband	
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) February 19, 1997 Chapel Lawn Memorial Gardens		21c. LOCATION—City or Town, State Scherverville, Indiana			
22. EMBALMER'S NAME Thomas G. Pruzin		22b. EMBALMER'S LICENSE NO. 1009893		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1009893		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE 783002453 6360 Broadway, Merrillville, IN 46410			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

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.

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

IMMEDIATE CAUSE OF DEATH
Cerebrovascular accident

CONDITIONS IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST
FEB 29 2000

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos
2 mos.

PART II Enter the cause of 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) **---**

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
Alexander Williams
LAKE COUNTY HEALTH COMMISSIONER

29c. MEDICAL LICENSE NO.
01025591

29d. DATE SIGNED (Month, Day, Year)
02-17-97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print)
Alexander Williams, MD
5555 N. State St., Ellettsville, IN 47421

31. HEALTH OFFICER'S SIGNATURE
[Signature]

32. DATE FILED (Month, Day, Year)
February 18, 1997

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

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.M.

34g. DATE PRONOUNCED DEAD (Month, Day, Year)
A. Yannuzzi
Colorado St.

34h. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes specify driver, passenger, pedestrian, etc.
00525 CS

Shirley 6897 C
Merrillville, In. 46400