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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. 0046-99

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TYPE/PRINT IN PERMANENT BLACK INK

INDIANA STATE DEPARTMENT OF HEALTH

15-29-9

CERTIFICATE OF DEATH

State No. ....

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

DECEDENT

Field	Value
1. DECEDENT—NAME (First, Middle, Last)	CLARA MARIE MANIS
2. SEX	Female
3a. TIME OF DEATH	5:59 PM
3b. DATE OF DEATH (Month, Day, Yr)	January 5, 1999
4. *SOCIAL SECURITY NUMBER	303-24-6523
5a. AGE—Last Birthday (Years)	73
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	March 10, 1925
7. BIRTHPLACE (City and State or Foreign Country)	Hobart, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	--
9a. 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)	7115 Delaware Street
9c. CITY, TOWN OR LOCATION OF DEATH	Merrillville
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Widowed
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)	Homemaker
12b. KIND OF BUSINESS/INDUSTRY	Own Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Merrillville
13d. STREET AND NUMBER	7115 Delaware Street
13e. ZIP CODE	46410
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Value
18. FATHER'S NAME (First, Middle, Last)	Theodore Schroeder
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Elfrieda Foreman

INFORMANT

Field	Value
20a. INFORMANT'S NAME (Type/Print)	Dianne Blatz
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	520 E. 70th Pl, Merrillville, IN 46410
20c. Relationship	Daughter

DISPOSITION

Field	Value
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)	January 9, 1999 Graceland Cemetery
21c. LOCATION—City or Town, State	Valparaiso, Indiana
22a. EMBALMER'S NAME	David Patton
22b. EMBALMER'S LICENSE NO.	29600056
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	David Patton (signature)
24b. LICENSE NUMBER (of Licensee)	29600056
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	PRUZIN BROS. FUNERAL SERVICE #3002453, 6360 Broadway, Merrillville, IN 46410

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cardiomyopathy	yrs
Conditions, if any, which give 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)	

Field	Value
PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I	Pulmonary emphysema
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	No
28a. WAS AN AUTOPSY PERFORMED?	No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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.

Field	Value
29b. SIGNATURE AND TITLE OF CERTIFIER	R. Devanathan M.D (signature)
29c. MEDICAL LICENSE NO.	01040141
29d. DATE SIGNED (Month, Day, Year)	1/8/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Raja G. Devanathan, M.D., 1400 S Lake Park Ave/Suite 1104, Hobart, IN 46342

HEALTH OFFICER

Field	Value
31. HEALTH OFFICER'S SIGNATURE	(signature) MD
32. DATE FILED (Month, Day, Year)	January 11, 1999

Field	Value
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)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	
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