

\* ATTENTION ESTATE: The Social Security # is 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 OF INDIANA

Local No. 2638-9V  
265313

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

LAKE COUNTY  
FILED

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

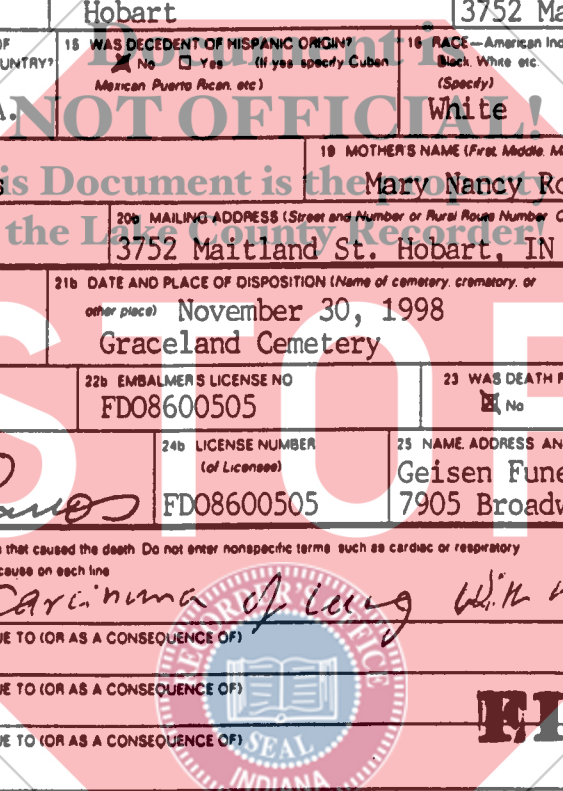
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Wilma Porter		2a SEX (Type M or F) Female		3a TIME OF DEATH 12:20a		3b DATE OF DEATH (Month Day Yr) November 25, 1998	
4 SOCIAL SECURITY NUMBER 296-24-0270		5a AGE—(Years) 78		5b UNDER 1 YEAR Months Days Hours		6 DATE OF BIRTH (Mo Day Yr) April 25, 1920	
7 BIRTHPLACE (City and State or Foreign Country) Jellico, Tennessee		8a WAS DECEDENT A US VETERAN? No		8b YEAR LAST SERVED IN US ARMED FORCES? ----		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient MORRIS W. GARNER RECORDERS <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other (Specify) Residence	
9b FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake 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) Emory J. Porter		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Waitress		12b KIND OF BUSINESS/INDUSTRY Restaurant	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hobart		13d STREET AND NUMBER 3752 Maitland Street	
13e ZIP CODE 46342		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican, etc)	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+) 11			
18 FATHER'S NAME (First Middle Last) Calip Powers				19 MOTHER'S NAME (First Middle Maiden Surname) Mary Nancy Rose			
20a INFORMANT'S NAME (Type/Print) Emory J. Porter				20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3752 Maitland St. Hobart, IN 46342		20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) November 30, 1998 Graceland Cemetery			21c LOCATION—City or Town State Valparaiso, Indiana		
22a EMBALMER'S NAME Alexis Thanos		22b EMBALMER'S LICENSE NO FDO8600505		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Alexis Thanos</i>		24b LICENSE NUMBER (of Licensee) FDO8600505		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, IN 46410			
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 Carcinoma of lung with metastasis 7 1/2 yr							
b DUE TO (OR AS A CONSEQUENCE OF)							
c DUE TO (OR AS A CONSEQUENCE OF)							
d DUE TO (OR AS A CONSEQUENCE OF)							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
Ca Break, slip metastasis slip chemo HPN slip Re-stroke, COPD renal failure				27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Alexander Williams MD</i>				29c MEDICAL LICENSE NO 01035695		29d DATE SIGNED (Month Day Year) 12/01/98	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. J.P. Sanghvi, 8127 Merrillville Road, Merrillville, Indiana 46410							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>						32 DATE FILED (Month Day Year) December 2, 1998	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
		34d PLACE OF INJURY—At home farm street factory, office building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED (If certificate is filed with THE LAKE COUNTY HEALTH DEPT) DEC 01 1998			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian <i>Alexander Williams MD</i> LAKE COUNTY HEALTH 50314					



FILED

unit # 27  
Key # 18-130-13  
Ridgewood Add to Gary hot 13 + North 1/2 of hot 14 Block 2