

* 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.

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INDIANA STATE DEPARTMENT OF HEALTH

STATE OF INDIANA
LAKE State No. 11
FILED FOR RECORD

Local No. 0378-00

CERTIFICATE OF DEATH

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) 2000 054964 Marietta Fields		2 SEX Female	2a TIME OF DEATH 8:35 AM	2b DATE OF DEATH (Month, Day, Yr) January 31, 2000	
4 SOCIAL SECURITY NUMBER 131-30-0854	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) February 21, 1934	
7 BIRTHPLACE (City and State or Foreign Country) Pittsburgh, PA	8a WAS DECEDENT A U.S. VETERAN? NO				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Methodist Hospital <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9a FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake		9b CITY, TOWN, OR LOCATION OF DEATH Merrillville		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) George W. Fields Sr.	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 Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 1008 Ralston St.	
13e ZIP CODE 46406	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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.)	16 RACE—American Indian, Black, White, etc. (Specify) Black	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12th		18 FATHER'S NAME (First, Middle, Last) Arthur Nowlin Sr.			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Annie Barnes		20a INFORMANT'S NAME (Type/Print) Donna Pittman			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17021 Pine Court Hazelcrest, IL 60429		20c Relationship Daughter			
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 5, 2000 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, IN	
22a EMBALMER'S NAME Rosenwald D. Allen Jr.		22b EMBALMER'S LICENSE NO. #29400047		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) #08700646		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83007704 Guy & Allen Funeral Directors Inc. 2959 W. 11th Avenue Gary, In 46404	
26 PART I Enter the disease, 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) Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF) Pneumonia with DUE TO (OR AS A CONSEQUENCE OF) cerebral aneurysm DUE TO (OR AS A CONSEQUENCE OF) Chronic Renal Failure PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Past stroke					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a WAS AN AUTOPSY PERFORMED? NO		28b WERE ANY OTHER FRIENDS PRESENT AT DEATH? 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 and due to the cause(s) as 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>[Signature]</i>		29c MEDICAL LICENSE NO. IN 25043		29d DATE SIGNED (Month, Day, Year) 2/4/2000	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Kristin Tim - 8300 Broadway Merrillville IN 46410					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> DATE FILED (Month, Day, Year) February 10, 2000					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34b 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.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CASH 9-11 AM

25x10