#36-40-17

* 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. 527

INDIANA STATE DEPARTMENT OF HEALTH

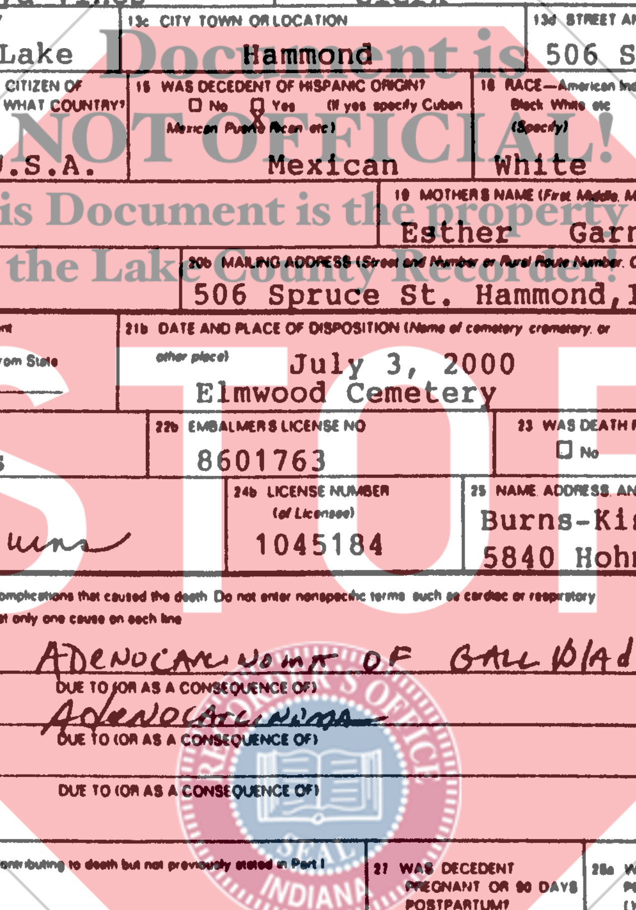
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

July 3, 2000 — Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK



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STOP

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Sylvia M. Vines
2 SEX	Female
3a TIME OF DEATH	9:55P M
3b DATE OF DEATH (Month Day Yr)	June 29, 2000
4 SOCIAL SECURITY NUMBER	303-46-47085
5a AGE—Last Birthday	58
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	July 21, 1941
7 BIRTHPLACE (City and State or Foreign Country)	E.Chicago, IN
8a WAS DECEDENT A US VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	None
9a PLACE OF DEATH (Check only one)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	506 Spruce St.
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife give maiden name)	Llyoyd Vines
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Clerk
12b KIND OF BUSINESS/INDUSTRY	N. Township
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	506 Spruce St.
13e ZIP CODE	46324
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 — Mexican
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+): –

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Charles Vasquez
19 MOTHER'S NAME (First Middle Maiden Surname)	Esther Garnica

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Lloyd Vines
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	506 Spruce St. Hammond, IN 46324
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	July 3, 2000 Elmwood Cemetery
21c LOCATION—City or Town, State	Hammond, IN
22a EMBALMER'S NAME	Brian T. Burns
22b EMBALMER'S LICENSE NO	8601763
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Thomas J. Burns (signature)
24b LICENSE NUMBER (of Licensee)	1045184
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish F.H. #3002819, 5840 Hohman Hammond, IN 46320

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)		Approximate Interval Between Onset and Death
a	Adenocarcinoma of Gallbladder metastatic	Months
b. DUE TO (OR AS A CONSEQUENCE OF)	Adenocarcinoma	Months
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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

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

FILED AUG 10 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2000 AUG 10 MORRIS W. CARTER RECORDER

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	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Alan Jones DO (signature)
29c MEDICAL LICENSE NO	0200064O
29d DATE SIGNED (Month Day Year)	July 3, 2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	A. Jones D.O. 929 Ridge Road Munster, IN 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Franklin D. Sepeda M.D. (signature)
32 DATE FILED (Month Day Year)	July 3, 2000

Field	Entry
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	

CASH 9.00 AM

2000 047429

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

25 X