* 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

Local No. 1629-00 State No. ....

119676

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): DOROTHY NEVERS
2 SEX: Female
3a TIME OF DEATH: 6:10 P M
3b DATE OF DEATH (Month Day Yr): July 9, 2000
4 *SOCIAL SECURITY NUMBER: 312-09-8187
5a AGE—Last Birthday (Years): 82
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day Yr): July 17, 1917
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): Lincolnshire Health Care Center
9c CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Widow
11 SURVIVING SPOUSE (If wife, give maiden name): N/A
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b KIND OF BUSINESS/INDUSTRY: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Merrillville
13d STREET AND NUMBER: 8380 Virginia Place
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?: ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
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+): 1

PARENTS

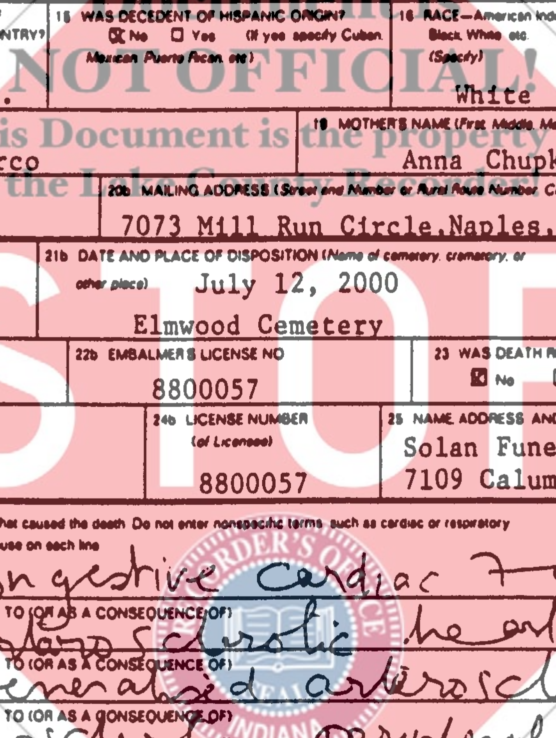
18 FATHER'S NAME (First, Middle, Last): Michael Durco
19 MOTHER'S NAME (First, Middle, Maiden Surname): Anna Chupka

INFORMANT

20a INFORMANT'S NAME (Type/Print): Sheila Demkovich
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7073 Mill Run Circle, Naples, FL. 34109
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 12, 2000 Elmwood Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: Dean G. Wagner
22b EMBALMER'S LICENSE NO: 8800057
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Dean G. Wagner (signature)
24b LICENSE NUMBER (of Licensee): 8800057
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Solan Funeral Home FH83002893, 7109 Calumet Ave., Hammond, In. 46324


Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP

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)
a. Congestive cardiac failure
DUE TO (OR AS A CONSEQUENCE OF)
b. arterosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Generalized arterosclerosis
DUE TO (OR AS A CONSEQUENCE OF)
d. arterosclerotic peripheral vascular disease

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

Approximate Interval Between Onset and Death

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

JUL 13 2000

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Gangrene (R) Leg, Dehydration

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): N/A

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

AUG 25 2000

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) and manner 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: K. Potti MD (signature)
29c MEDICAL LICENSE NO.: IN ...
DATE SIGNED (Month Day Year): 7/13/2000

PETER BENJAMIN LAKE COUNTY AUDITOR

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Krishnan Potti, M.D. 8300 Broadway Ave., Merrillville, IN. 46410 219-769-4616

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander ... Williams, MD (signature)
32 DATE FILED (Month Day Year): July 13, 2000

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

02015

COMMUNITY TITLE COMPANY FILE NO 19781

2000 050216

SDH06-004 State Form 10110 (R5/1-99)