

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

State No.

Local No. 1905-00

TYPE/PRINT IN PERMANENT BLACK INK

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

STATE OF INDIANA LAKE COUNTY

DECEDENT

PARENTS

INFORMANT

DISPOSITION

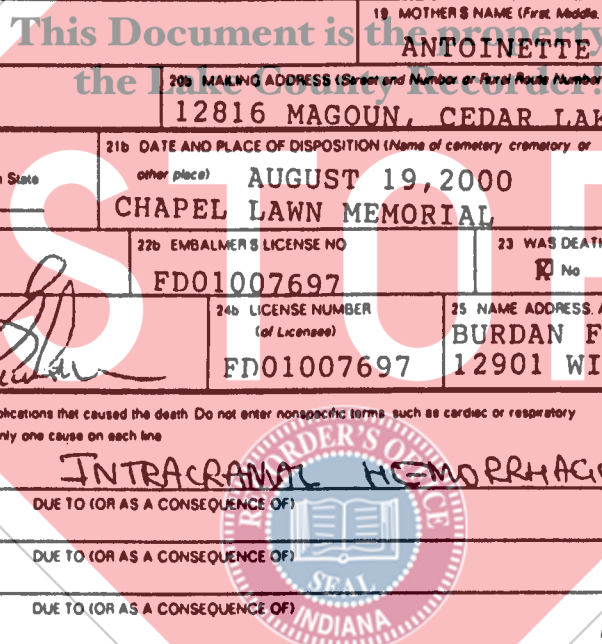
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) LORRAINE A. DAVIS		2a SEX FEMALE	3a TIME OF DEATH 2:30A M	3b DATE OF DEATH (Month, Day, Yr) AUGUST 17, 2000	
4 SOCIAL SECURITY NUMBER 345-16-4587	5a AGE—Last Birthday 20007062293	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) FEB 28 201 1928	
7 BIRTHPLACE (City and State or Foreign Country) CHICAGO, IL	8a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
8b WAS DECEDENT A US VETERAN? NO	8c YEAR LAST SERVED IN US ARMED FORCES? N/A	9b FACILITY NAME (If not institution, give street and number) ST ANTHONY MEDICAL CENTER			
9c CITY, TOWN OR LOCATION OF DEATH CROWN POINT		9d COUNTY OF DEATH LAKE			
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) WILLIAM	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 CEDAR LAKE	13d STREET AND NUMBER 12816 MAGOUN STREET		
13e ZIP CODE 46303	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.)	16 RACE—American Indian, Black, White, etc (Specify) WHITE	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12		17 College (11-4 or 5+)			
18 FATHER'S NAME (First Middle Last) CHARLES ROMANO		19 MOTHER'S NAME (First Middle, Maiden Surname) ANTOINETTE DUDACK			
20a INFORMANT'S NAME (Type/Print) WILLIAM F. Davis		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12816 MAGOUN, CEDAR LAKE, IN 46303		20c Relationship HUSBAND	
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) AUGUST 19, 2000 CHAPEL LAWN MEMORIAL		21c LOCATION—City or Town, State SCHERERVILLE, IN	
22a EMBALMER'S NAME WILLIAM E. BURDAN		22b EMBALMER'S LICENSE NO. FDO1007697		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>William E. Burdan</i>		24b LICENSE NUMBER (of Licensee) FD01007697		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURDAN FUNERAL HOME FH83002461 12901 WICKER AVE. CEDAR LAKE, IN	
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. INTRACRANIAL HEMORRHAGE				Approximate Interval Between Onset and Death 5 days	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. INTRACRANIAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF)				FILED AUG 28 2000	
Conditions if any which gave 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)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Carcinoma colon Carcinoma neck soft tissue				27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) (no)	
28a WAS AN AUTOPSY PERFORMED? PETER BENJAMIN LAKE COUNTY AUDITOR				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 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>Rakesh Kansal MD</i>			
29c MEDICAL LICENSE NO. IN 01038984		29d DATE SIGNED (Month, Day, Year) 8/17/00			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. RAKESH 3100 45th STREET, HIGHLAND, IN 46322					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>				32 DATE FILED (Month, Day, Year) Aug 18, 2000	
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) (File with HEALTH DEPT)	34d DESCRIBE HOW INJURY OCCURRED LAKE COUNTY
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) AUG 18 2000			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) (no)		LAKE COUNTY HEALTH COMMISSIONER 02115 <i>Cash</i>	

E20ft of S. 37 7/9 rds of E 1/2 NW S. 20 T. 34 R. 9, Key #6-17-15; unit #05
Pt of SE 1/4 NW 1/4 S. 20 T. 34 R. 9, Key #6-17-18; unit #05





Official Stamp

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 062293

2000 AUG 28 PM 2:50

REC. CENTER
COLUMBIANA

Document Mail Back to
Information Sheet

This is where you want the recorded document sent back to when it has completed the recording process.

Name

WILLIAM DAVIS

Address

12816 MAGOON

City St Zip

CEDAR LAKE IN 46303

Telephone

219-374-5229

Signature Printed

WILLIAM DAVIS

Signature Written

William Davis

Date of Signature

8-28-00

Check Number

Check Amount

Cash

Office Use Only

Check Equals Amount Due Yes No

Total

10-

Initials

WD