

\*ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 3195-94

CERTIFICATE OF DEATH

State No. ....

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) Virginia M. Fulton		2 SEX Female	3a TIME OF DEATH 6:35a.m.	3b DATE OF DEATH (Month Day, Yr) December 9, 1994	
4 SOCIAL SECURITY NUMBER 313-64-0462	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) Dec. 15, 1920	
7 BIRTHPLACE (City and State or Foreign Country) Terre Haute	8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> <del>Resident</del> <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Methodist Southlake Campus		9c CITY, TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Russell Fulton	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife	12b KIND OF BUSINESS/INDUSTRY 000		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 3375 Pennsylvania St.		
13e ZIP CODE 46409	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 by highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+)		18 FATHER'S NAME (First Middle Last) Fred Hampe			
19 MOTHER'S NAME (First Middle, Maiden Surname) Agnes Fitz		20 INFORMANT'S NAME (Type/Print) Russell Fulton			
20a MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3375 Pennsylvania St. Gary, In 46408		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) December 12, 1994 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, Indiana	
22a EMBALMER'S NAME Anthony S. Rendina Jr.		22b EMBALMER'S LICENSE NO. FD01010402	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>		24b LICENSE NUMBER (of Licensee) FD01010402	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home PH83007819 5100 Cleveland St. Gary, Ind. 46408		
26 PART I Enter the disease, injuries, or complications that caused the death. Do not enter non-specific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Disease or condition resulting in death) HYPOTENSION AND APNEA HEALTH DEPT. COMPLETE COPY OF THE ABOVE IS TO BE FORWARDED TO THE STATE DEPARTMENT OF HEALTH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DEC 16, 1994 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH FILED OCT 16 2000					
26 PART II Other conditions considered as contributing to death but not previously stated in Part I <i>Alexander B. Williams, MD LAKE COUNTY HEALTH COMMISSIONER</i>		27 WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) PETER BENJAMIN LAKE COUNTY AUDITOR		28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>N Gupta MD</i>		29c MEDICAL LICENSE NO. D1042940	29d DATE SIGNED (Month Day, Year) DEC. 16 <sup>th</sup> 1994		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) N. GUPTA, 125 E 89 <sup>th</sup> AVE, MERRILLVILLE IN 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander B. Williams, MD</i>			32 DATE FILED (Month Day, Year) December 16, 1994		
33 MANNER OF DEATH <input checked="" 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 01212
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) DEC. 9 <sup>th</sup> 1994		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

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