

\* 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. 104

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Mary Susanna Hautsch		2 SEX Female		3a. TIME OF DEATH 6:00 A.M.		3b. DATE OF DEATH (Month, Day, Year) April 9, 2000	
4. SOCIAL SECURITY NUMBER 306-14-5229		5a. AGE—Last Birthday (Years) 83		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) September 12, 1916		7. BIRTHPLACE (City and State or Foreign Country) Mitchell, 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 <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			
9b. FACILITY NAME (If not institution, give street and number) St Catherine Hospital				9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS Widowed		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) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Highland		13d. STREET AND NUMBER 2537 Highway Ave	
13e. ZIP CODE 46322		13f. INSIDE CITY LIMITS <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 last highest grade completed) 11		18. FATHER'S NAME (First, Middle, Last) Ralph Riggs			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Roxie Isom		20a. INFORMANT'S NAME (Type/Print) Arletta J. Schaefer		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9010 Cottage Grove Pl., Highland, IN 46322		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) April 12, 2000 Chapel Lawn Memorial Gardens		21c. LOCATION—City or Town, State Schererville, Indiana			
22a. EMBALMER'S NAME Henry Blake		22b. EMBALMER'S LICENSE NO. FDO 1019406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR		24b. LICENSE NUMBER (of Licensee) FDO 1006015		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc 2828 Highway Ave Highland, IN 46322 FH83003035			
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) Pneumonia DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? No		28a. WAS AN AUTOPSY PERFORMED? No		28b. 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 [Signature] MD		29c. MEDICAL LICENSE NO. 01049668		29d. DATE SIGNED (Month, Day, Year) 4/17/00	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. S. Lewis, 3045 Ridge Road Highland 46322							
31. HEALTH OFFICER'S SIGNATURE [Signature]		32. DATE FILED (Month, Day, Year) 4-17-00				33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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, Zip Code) 9.00 E.P. 3993			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.					

