8 CCS

*** 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. 2124-99 43743

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ADRA E. PHILLIPS
2002 042777
2. SEX: Female
3a. TIME OF DEATH: 9:20 PM
3b. DATE OF DEATH (Month, Day, Yr): September 25, 1999
4. *SOCIAL SECURITY NUMBER: 307-20-0762
5a. AGE—Last Birthday (Years): 82
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Month, Day, Yr): June 4, 1917
7. BIRTHPLACE (City and State or Foreign Country): Hoosier, Illinois
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 2115 East State Road 231
9c. CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): --
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: Crown Point
13d. STREET AND NUMBER: 2115 East State Road 231
13e. ZIP CODE: 46307
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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Sydney O'Dell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Tolliver

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Don A. Phillips
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Park Street, Crown Point, IN 46307
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 29, 1999 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Henry Blake
22b. EMBALMER'S LICENSE NO: 0109406
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN & LITTLE FUNERAL SERVICE #3001261, 811 E Franciscan Dr, Crown Point, IN 46307

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 Metastatic Adenocarcinoma of Unknown Primary — Approximate Interval Between Onset and Death: 3 months

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):

FILED
MAY 07 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: 0

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28. [illegible] EXAMINED: No
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): --

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.
☐ [illegible] To the best of my knowledge, 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: JA Kacmar M.D.
29c. MEDICAL LICENSE NO: 01027088
29d. DATE SIGNED (Month, Day, Year): 9/27/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Joseph Kacmar, M.D., 123 North Court Street, Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Pilliod M.D.
32. DATE FILED (Month, Day, Year): Sept 27 1999
I CERTIFY THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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): 606608 SEP 27 1999
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian

Alexander S. Pilliod M.D.
LAKE COUNTY HEALTH COMMISSIONER

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

9.00 P
CS