

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. 2019-01

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

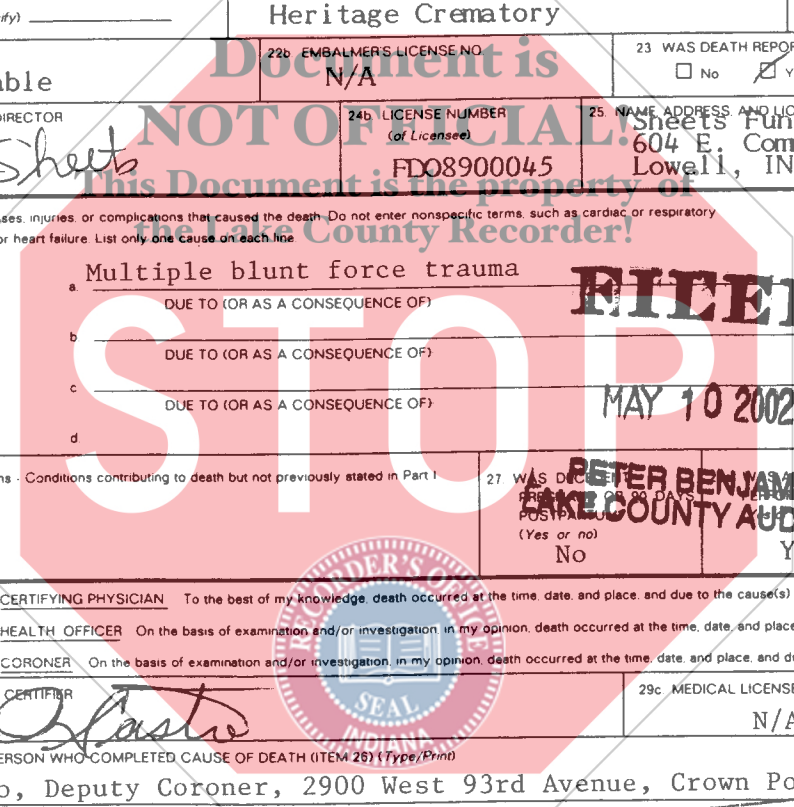
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle, Last) <b>Marjorie R. Fedler</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>05:34P</b>	3b DATE OF DEATH (Month, Day, Yr) <b>September 10, 2001</b>	
4 *SOCIAL SECURITY NUMBER <b>316-22-8441</b>		5 UNDER 1 DAY Months: <b>09</b> Days: <b>25</b>	6 DATE OF BIRTH (Mo, Day, Yr) <b>Apr 20, 1926</b>	7 BIRTHPLACE (City and State or Foreign Country) <b>Lowell, IN</b>	
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) <b>Route 2 - 1/4 mile East of I-65</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>Lowell</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>William Fedler</b>	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Librarian</b>	12b KIND OF BUSINESS/INDUSTRY <b>School System</b>		
13a RESIDENCE—STATE <b>IN</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>Lowell</b>	13d STREET AND NUMBER <b>350 Eastland Circle</b>		
13e ZIP CODE <b>46356</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-8) <b>12</b> College (1-4 or 5+) <b>2002</b>		18 FATHER'S NAME (First, Middle, Last) <b>Murry Turner</b>			
19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel Craft</b>		20a INFORMANT'S NAME (Type/Print) <b>William Fedler</b>			
20b MAIN ADDRESS AND RURAL ROUTE NUMBER, City or Town, State, Zip Code <b>350 Eastland Circle, Lowell, IN 46356</b>		20c Relationship <b>Husband</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>September 13, 2001 Heritage Crematory</b>		21c LOCATION—City or Town, State <b>Portage, IN</b>	
22a EMBALMER'S NAME <b>Not applicable</b>		22b EMBALMER'S LICENSE NO. <b>N/A</b>		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <b>Ken Sheets</b>		24b LICENSE NUMBER (of Licensee) <b>FDO8900045</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Sheets Funeral Home, 604 E. Commercial Ave., Lowell, IN 463004277</b>		
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. <b>Multiple blunt force trauma</b> DUE TO (OR AS A CONSEQUENCE OF)					
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					
27 WAS DEATH CAUSED BY A MOTOR VEHICLE ACCIDENT? (Yes or no) <b>No</b>		28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>Yes</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>Yes</b>	
29a CERTIFIER (Check only one) <b>Deputy</b> <input 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 checked="" 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 <b>Saul Castro</b>		29c MEDICAL LICENSE NO. <b>N/A</b>		29d DATE SIGNED (Month, Day, Year) <b>September 12, 2001</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) <b>Paul R. Castro, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307</b>					
31 HEALTH OFFICER'S SIGNATURE <b>Susan W. Best, D.O.</b>					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" 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) <b>Sept. 10, 2001</b>	34b TIME OF INJURY <b>Unknown</b>	34c INJURY AT WORK? (Yes or no) <b>No</b>	34d RESCUE HOW INJURY OCCURRED <b>Vehicle accident</b>
34a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		34b LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Route 2 - 1/4 mile East of I-65, Lowell, Indiana</b>			
34g DATE PRONOUNCED DEAD (Month, Day, Year) <b>September 10, 2001</b>		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>Yes. Passenger.</b>			



MORRIS W. CARTER  
 RECORDER  
 2002 MAY 14 PM 2:20  
 FILED IN RECORDS OF THE CLERK OF THE COUNTY OF LAKE INDIANA

9:00  
000-54 #269