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.

Local No. 2414-01
92280

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. 19-105-1 / 19-105-2 (Key #)

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

2002 046067
2002 MAY 16 PM 3:09
MORRIS W. CARTER RECORDER
FILED FOR RECORD

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased—Name (First, Middle, Last)	MARY JO STINNETT
2. Sex	Female
3a. Time of Death	10:25p
3b. Date of Death (Month, Day, Yr)	October 25, 2001
4. Social Security Number	406-56-3334
5a. Age—Last Birthday (Years)	59
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo, Day, Yr)	May 10, 1942
7. Birthplace (City and State or Foreign Country)	Carrollton Kentucky
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death	Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	St. Mary Medical Center
9c. City, Town, or Location of Death	Hobart
9d. County of Death	Lake
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	Charles Stinnett
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	
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town, or Location	Lake Station
13d. Street and Number	2174 Vigo St.
13e. Zip Code	46405
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	White
17. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12)	12
College (1-4 or 5+)	

PARENTS

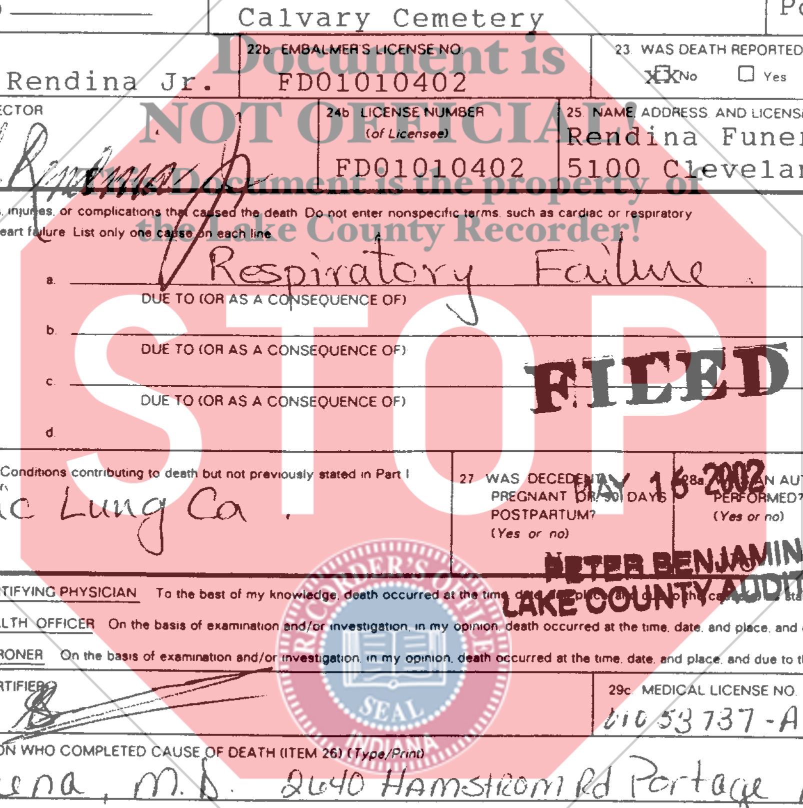
Field	Value
18. Father's Name (First, Middle, Last)	Early Gibson
19. Mother's Name (First, Middle, Maiden Surname)	Edith Chambers

INFORMANT

Field	Value
20a. Informant's Name (Type/Print)	Charles Stinnett
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2174 Vigo St. Lake Station, IN 46405
20c. Relationship	Husband

DISPOSITION

Field	Value
21a. Method of Disposition	☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	October 29, 2001 Calvary Cemetery
21c. Location—City or Town, State	Portage, Indiana
22a. Embalmer's Name	Anthony S. Rendina Jr.
22b. Embalmer's License No.	FD01010402
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD01010402
25. Name, Address, and License Number of Funeral Home	Rendina Funeral HOme FH83007819 5100 Cleveland St. GAry, In46408



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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Respiratory Failure	
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: Metastatic Lung Ca.

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)

28a. Was an Autopsy Performed? (Yes or no)

28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)

FILED
MAY 16 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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.
- ☐ 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.
- ☐ 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.

Field	Value
29b. Signature and Title of Certifier	[signature]
29c. Medical License No.	01053737-A
29d. Date Signed (Month, Day, Year)	10-29-01
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Samir Saxena, M.D. 2640 Hamstrom Rd Portage IN 46368

HEALTH OFFICER

Field	Value
31. Health Officer's Signature	Susan D. Best, D.O.
32. Date Filed (Month, Day, Year)	October 29, 2001

Field	Value
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)	
34g. Date Pronounced Dead (Month, Day, Year)	
34h. Motor Vehicle Accident? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
001389
OCT 29 2001

9.00 M.V. ckh

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