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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

1346LIC02

#43 53-65-2

179026 TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Carolyn J. Woodall		2. SEX Female		3a. TIME OF DEATH 1:15p M		3b. DATE OF DEATH (Month, Day, Yr.) May 29, 2001	
4. *SOCIAL SECURITY NUMBER 354-67-6600		5a. AGE--Last Birthday (Years) 45		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo. Day, Yr) August 19, 1955		7. BIRTHPLACE (City and State or Foreign Country) Chicago, 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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice Center			
9b. FACILITY NAME (If not institution, give street and number) VNA Mary Bartz Hospice Center				9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso		9d. COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Ronald Woodall		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Secretary		12b. KIND OF BUSINESS/INDUSTRY Legal	
13a. RESIDENCE--STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hobart		13d. STREET AND NUMBER 6400 Colorado St.	
13e. ZIP CODE 46342		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Caucasian	
16. RACE--American Indian, Black, White, etc. (Specify) Caucasian		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 1					
18. FATHER'S NAME (First, Middle, Last) Donald Holmberg				19. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Rodgers			
20a. INFORMANT'S NAME (Type/Print) Ronald Woodall				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 Colorado St. Hobart, IN. 46342		20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" 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) June 01, 2001 Oakland Memory Lane			21c. LOCATION (City or Town, State) Dolton, Illinois		
22a. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. N/A		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald E. White</i>		24b. LICENSE NUMBER (of Licensee) FD08700086		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home, 8178 Cline Avenue, Schererville, Indiana, 46375			
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. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death)							
a. Cardio Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):							
b. Hepatic Failure and Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):							
c. IDDM DUE TO (OR AS A CONSEQUENCE OF):							
d. Multiple Sclerosis							
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.							
Seizure disorders							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or No) 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.		29c. MEDICAL LICENSE NO. 01031797		29d. DATE SIGNED (Month, Day, Year) May 31, 2001			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Shashikant R. Rane 10 N. Michigan Avenue Hobart, IN 46342					
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Bobbick</i>						32. DATE FILED (Month, Day, Year) May 31, 2001	
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) MAY 28 2002		34b. TIME OF INJURY		34c. INJURY A RESULT OF (Yes or no)	
34e. PLACE OF INJURY--At home, farm, street, factory, office building, etc (Specify)		34d. DESCRIBE HOW INJURY OCCURRED PETER BENJAMIN LAKE COUNTY AUDITOR					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT (Yes or No)					

Unit # 43 Schnabel Acres lot 2 Key # 53-65-2

2002 MAY 28 PM 2:54

FILED

MAY 28 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

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