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PORTER COUNTY

CERTIFICATE OF DEATH

18-14-8

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED-NAME (First Middle Last): NAOMI J. MARLER
- 2. SEX: Female
- 3a. TIME OF DEATH: 5:25PM
- 3b. DATE OF DEATH (Month Day Yr): March 2, 1997
- 4. SOCIAL SECURITY NUMBER: 305-28-6852
- 5a. AGE - Last Birthday (Years): 67
- 5b. UNDER 1 YEAR (Months / Days):
- 5c. UNDER 1 DAY (Hours / Minutes):
- 6. DATE OF BIRTH (Mo Day Yr): Oct 29, 1929
- 7. BIRTHPLACE (City and State or Foreign Country): Gary, 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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)
- 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): Jack W. Marler
- 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: Home
- 13a. RESIDENCE - STATE: Indiana
- 13b. COUNTY: Lake
- 13c. CITY TOWN OR LOCATION: Hobart
- 13d. STREET AND NUMBER: 1105 S. Ash Street
- 13e. ZIP CODE: 46342
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: USA
- 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): 12; College (1-4 or 5+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Francis Cuthbert
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Huff

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Jack W. Marler
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1105 S. Ash Street, Hobart, IN 46342
- 20c. Relationship: Husband

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mar 6, 1997 Chapel Lawn Memorial Gardens
- 21c. LOCATION - City or Town State: Schererville, Indiana
- 22a. EMBALMER'S NAME: James J. Krause
- 22b. EMBALMER'S LICENSE NO.: FDO1006463
- 23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
- 24b. LICENSE NUMBER (of Licensee): FDO1006463
- 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. PANCREATIC CANCER	2 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF) b.	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c.	
	DUE TO (OR AS A CONSEQUENCE OF) d.	

- PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: BREAST CANCER
- 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): 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.
  - ☐ 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.
- 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
- 29c. MEDICAL LICENSE NO:
- 29d. DATE SIGNED (Month Day Year): 3/5/97
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Timothy Ames MD, 1101 E. Glendale Blvd., Valparaiso, IN 46383

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Gary A. Balester MD
- 32. DATE FILED (Month Day Year): March 6, 1997

- 33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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):
- 34g. DATE PRONOUNCED DEAD (Month, Day, Year):
- 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

002309 9.00 KP Cash

FILED JUL 31 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

Nº 044141

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Babcock, MD
HEALTH OFFICER

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