(23) 9-219-31

* 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. 5661

HAMILTON COUNTY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

State No. ....

923-6692

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

8-D-03

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Lillian Mildred Ryan
2. SEX	Female
3a. TIME OF DEATH	5:30 PM
3b. DATE OF DEATH (Month, Day, Yr.)	August 13, 2003
4. *SOCIAL SECURITY NUMBER	309-42-6109
5a. AGE-Last Birthday (Year's)	80
5b. UNDER 1 YEAR Months Days	
5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr)	December 7, 1922
7. BIRTHPLACE (City and State or Foreign Country)	Whiting, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1945
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)	89 Hawthorne Drive
9c. CITY, TOWN, OR LOCATION OF DEATH	Carmel
9d. COUNTY OF DEATH	Hamilton
10. MARITAL STATUS (Specify)	Widowed
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENTS USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Office Manager
12b. KIND OF BUSINESS/INDUSTRY	Machine Shop
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Crown Point
13d. STREET AND NUMBER	11 Walnut Parkway
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)	12
College (1-4 or 5 +)	2
18. FATHERS NAME (First, Middle, Last)	Marian Javorcic
19. MOTHER'S NAME (First Middle, Maiden Surname)	Agatha Holjac
20a. INFORMANT'S NAME (Type/Print)	Michael J. Ryan
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City, or Town, State, Zip Code)	2241 N. Coldspring Rd., Arlington Heights, IL 60004
20c. Relationship	Son
21a. METHOD OF DISPOSITION	☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	August 16, 2003 SS John and Joseph Cemetery
21c. LOCATION—City or Town, State	Hammond, Indiana
22a. EMBALMERS NAME	Jason C. Stroup
22b. EMBALMERS LICENSE NO	FD09200100
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Edward L. Smith (signature)
24b. LICENSE NUMBER (of Licensee)	FD001019228
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83003409 Flanner & Buchanan Funeral Center-Carmel 325 East Carmel Drive, Carmel, Indiana 46032

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. acute myocardial infarction	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) b.	
	DUE TO (OR AS A CONSEQUENCE OF) c.	
	DUE TO (OR AS A CONSEQUENCE OF) d.	

Field	Entry
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.	Congestive Heart Failure
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)	N/A

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	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Robert D. Nation MD (signature)
29c. MEDICAL LICENSE NO	01021550A
29d. DATE SIGNED (Month, Day, Year)	August 21, 2003
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Robert D. Nation, M.D., 8450 Payne Road, Ste. 100, Indianapolis, Indiana 46268
31. HEALTH OFFICER'S SIGNATURE	Charles Harris, MD
32. DATE FILED (Month, Day, Year)	AUG 21 2003
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.	

Charles Harris, MD

Hamilton County Health Officer

DATE AUG 21 2003

This photocopy is a true copy of the record on file with the Hamilton County Health Dept.

FILED SEP 30 2003 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR 002674

2003 060221

SDH06-004 State Form 10110 (R5/1-99)

TICOR TITLE INSURANCE