ITION ESTATE: The Social Security # is quested by this state agency in order to ts statutory responsibility. Disclosure is and there will be no penalty for refusal.

No. 631-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 36-166-79

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

1. DECEASED—NAME (First, Middle, Last): Diana Louise Yoldash			2. SEX: Female	3a. TIME OF DEATH: 6:40 P M	3b. DATE OF DEATH (Month, Day, Yr.): January 14, 2002
4. *SOCIAL SECURITY NUMBER: 314-86-7602	5a. AGE—Last Birthday (Years): 33	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.): February 11,1968	7. BIRTHPLACE (City and State or Foreign Country): Hammond, IN
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 ☐ Other (Specify) ☐ Residence	
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake		9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville		9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Ismail Yoldash	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: Hammond		13d. STREET AND NUMBER: 7417 McCook Ave.	
13e. ZIP CODE: 46323	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): 10 / College (1-4 or 5+):
18. FATHER'S NAME (First, Middle, Last): James Mikhel		19. MOTHER'S NAME (First, Middle, Maiden Surname): Sally Banner			
20a. INFORMANT'S NAME (Type/Print): Ismail Yoldash		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7417 McCook Ave., Hammond, IN 46323		20c. Relationship: Husband	
21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 18, 2002 Ridgelawn Cemetery		21c. LOCATION—City or Town, State: Gary, Indiana	
22a. EMBALMER'S NAME: Casmir Pulaski		22b. EMBALMER'S LICENSE NO: FD08900012		23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR: Henry Allen Hunt		24b. LICENSE NUMBER (of Licensee): FD29900123		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH19900009 Virgil Huber Funeral Home 7051 Kennedy Ave., Hammond, IN 46323	

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.	Smoke inhalation	Unknown
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

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)
No	Yes	Yes

FILED
FEB 12 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

29a. CERTIFIER (Check only one): Deputy
☐ 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
	N/A	March 5, 2002

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

32. DATE FILED (Month, Day, Year): March 15, 2002

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	Jan 13,2002	Unknown	No	House Fire

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)
Residence	7417 McCook Avenue Hammond, Indiana

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
January 14, 2002	No

000794

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