ATTENTION ESTATE: The Social Security # is eing requested by this state agency in order to ursue its statutory responsibility. Disclosure is oluntary and there will be no penalty for refusal.

ocal No. 69

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. # 30-623-1

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

YPE/PRINT IN ERMANENT BLACK INK

ECEDENT

1. DECEASED—NAME (First, Middle, Last): Beatrice Hill
2. SEX: Female
3a. TIME OF DEATH: 9:15P. M
3b. DATE OF DEATH (Month Day Yr): March 5, 2004
4. *SOCIAL SECURITY NUMBER: 436-30-5677
5a. AGE—Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): July 22, 1920
7. BIRTHPLACE (City and State or Foreign Country): Bachelor, Louisiana
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): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Charles Hill
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:
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 2306 Lituanica
13e. ZIP CODE: 46312
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5 +):

ARENTS

18. FATHER'S NAME (First, Middle, Last): James McCall
19. MOTHER'S NAME (First, Middle, Maiden Surname): Pearline Haynes

IFORMANT

20a. INFORMANT'S NAME (Type/Print): Julie McCall-Harris
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 444 Vaughn Circle Aurora, Ilinois 60504
20c. Relationship: Niece

SPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 9, 2004 Regional Cremation Services
21c. LOCATION—City or Town, State: Munster, Indiana
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton & Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, IN 46312 FH83001520

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STOP

AUSE OF EATH

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. Atherosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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? No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No

FILED
APR 26 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

RTIFIER

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: 01035702
29d. DATE SIGNED (Month, Day, Year): 3/8/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MANSUETO SILVERMAN 3641 RIDGE RD HIGHLAND 46322

ALTH FICER

31. HEALTH OFFICER'S SIGNATURE: Dr Timothy Baykouch
32. DATE FILED (Month, Day, Year): March 9, 2004

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.

9.00 AS Cp

002107

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