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PORTER COUNTY CERTIFICATE OF DEATH

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

84118

TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 920040809

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Beulah M. Boling
2. SEX: Female
3a. TIME OF DEATH: 6:25a M
3b. DATE OF DEATH (Month, Day, Yr.): July 19, 2002
4. *SOCIAL SECURITY NUMBER: 316-32-2374
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): Sept. 18, 1927
7. BIRTHPLACE (City and State or Foreign Country): Meinfee Co. Kentucky
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) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 5715 Dovedale Ave.
9c. CITY, TOWN, OR LOCATION OF DEATH: Portage
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Clayton Boling
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: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Porter
13c. CITY, TOWN, OR LOCATION: Portage
13d. STREET AND NUMBER: 5715 Dovedale Ave.
13e. ZIP CODE: 46368
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 9; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Charlie Ballard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Morison

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Clayton Boling
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5715 Dovedale Ave. Portage, IN. 46368
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 24, 2002 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN.
22a. EMBALMER'S NAME: Raymond E. White
22b. EMBALMER'S LICENSE NO: FD08700086
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD08700086
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn F.H. FH19900051 P.O. Box 847 Schererville, IN. 46375

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Melanoma c metastasis	12 months
b.	DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.	DUE TO (OR AS A CONSEQUENCE OF):	

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): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

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: 01019610B
29d. DATE SIGNED (Month, Day, Year): 7/19/02
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. J. Tyrrell Jones Clinic 110 Ridge Road Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Babioke [signature]
32. DATE FILED (Month, Day, Year): July 24, 2002

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.

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SDHOS 004 State Form 10110 (R5/1-00)

FILED MAY 10 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

2004 038203 FILED FOR RECORD LAKE COUNTY STATE OF INDIANA 2004 MAY 11 AM MORRIS W. CARTER RECORDER

No. 156159

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA

THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

HEALTH OFFICER