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. 377-04

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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Gayla L George
2. SEX	Female
3a. TIME OF DEATH	6:35 PM
3b. DATE OF DEATH (Month, Day, Yr)	February 8, 2004
4. *SOCIAL SECURITY NUMBER	— —
5a. AGE—Last Birthday (Years)	50
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Jan. 7, 1954
7. BIRTHPLACE (City and State or Foreign Country)	Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	None
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)	Munster Med-Inn
9c. CITY, TOWN, OR LOCATION OF DEATH	Munster
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	John George
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	School Librarian
12b. KIND OF BUSINESS/INDUSTRY	Library
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	St John
13d. STREET AND NUMBER	11942 90th Ave.
13e. ZIP CODE	46373
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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+): 5+

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Terry Foote
19. MOTHER'S NAME (First, Middle, Maiden Surname)	N.A.

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Dr. John George
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	11942 90th Ave. St. John, IN 46373
20c. Relationship	Husband

DISPOSITION

Field	Entry
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)	February 11, 2004 Regional Cremation SV
21c. LOCATION—City or Town, State	Munster, IN
22a. EMBALMER'S NAME	—
22b. EMBALMER'S LICENSE NO.	
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	1021590
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321

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.	CARDIOPULMONARY ARREST	
DUE TO (OR AS A CONSEQUENCE OF) b.	GLIOBLASTOMA	
DUE TO (OR AS A CONSEQUENCE OF) c.	SEIZURE DISORDER	
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

Field	Entry
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)	

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	032154
29d. DATE SIGNED (Month, Day, Year)	2/9/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Parul Doshi 9800 Valparaiso CT. Munster, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Susan ... D.O. [signature]
32. DATE FILED (Month, Day, Year)	February 11, 2004

Field	Entry
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.	

THIS CERTIFIES THE ABOVE IS A TRUE & COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

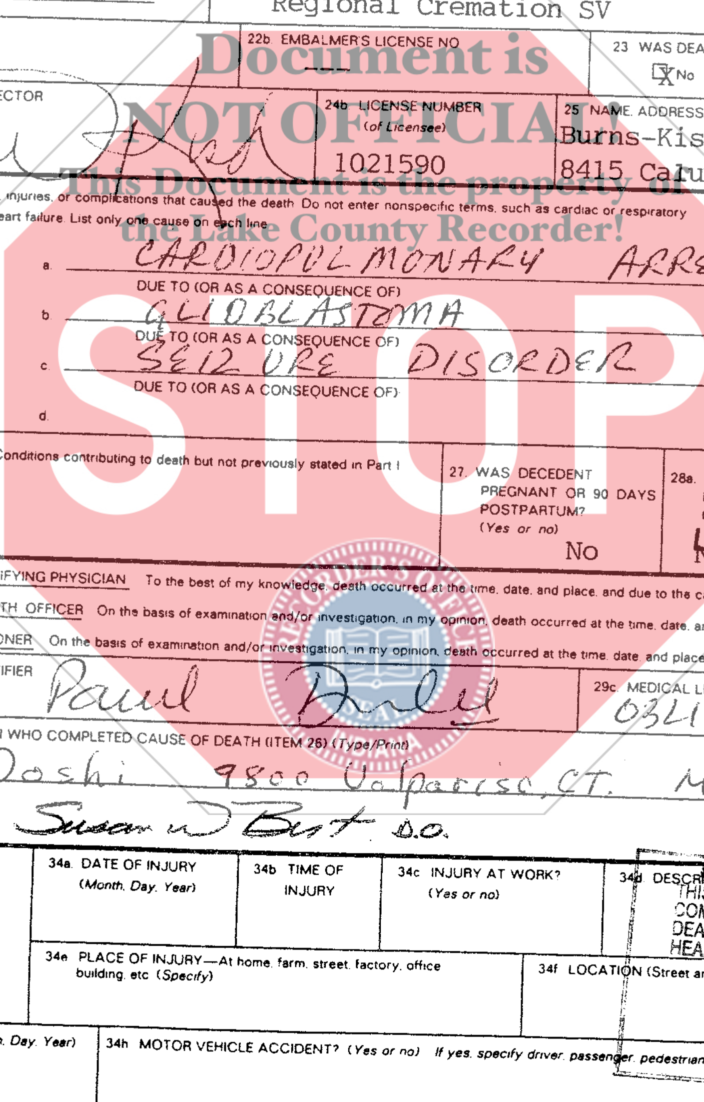
FEB 11 2004

001281

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2004 MAY 17 ... MORRIS ... RECORDER

2004 040443

FILED MAY 17 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR



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