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* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. C095-02

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

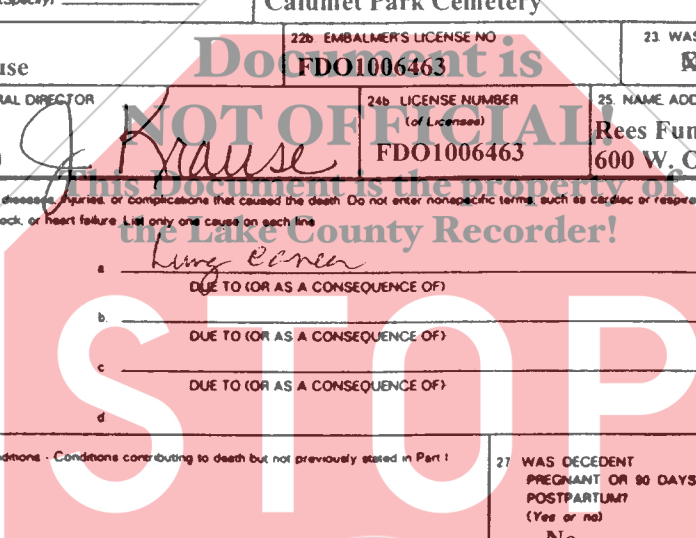
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) SUZANNE K. THOMAS		2 SEX Female	3a TIME OF DEATH 8:30 AM	3b DATE OF DEATH (Month, Day, Year) January 14, 2002
4 SOCIAL SECURITY NUMBER 304-58-7831	5a AGE—Last Birthday (Years) 51	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) October 22, 1950
7 BIRTHPLACE (City and State or Foreign Country) Gary Indiana	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: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c CITY, TOWN, OR LOCATION OF DEATH Hobart	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Divorced	11 SURVIVING SPOUSE (If wife, give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Dog Grooming	12b KIND OF BUSINESS/INDUSTRY Self-Employed	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hobart	13d STREET AND NUMBER 4133 Mississippi Street	
13e ZIP CODE 46342	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+)		18 FATHER'S NAME (First, Middle, Last) Carl L. Martikean		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Sheila Hilton		20a INFORMANT'S NAME (Type/Print) Carl L. Martikean		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4142 Mississippi Street, Gary, IN 46409		20c Relationship Father		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Jan 17, 2002 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville IN
22a EMBALMER'S NAME James J. Krause		22b EMBALMER'S LICENSE NO. FDO1006463		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b LICENSE NUMBER (of Licensed) FDO1006463		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488
26 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Lung cancer 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.		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) No		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>B. Tara MD</i>		
29c MEDICAL LICENSE NO. 01031667		29d DATE SIGNED (Month, Day, Year) 1/15/02		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Pimpa J. Tara MD 8127 Merrillville Road, Merrillville, IN 46410				
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Best D.O.</i>				32 DATE FILED (Month, Day, Year) JAN 15 2004
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no) FILED
34d PLACE OF INJURY—At home, farm, street, factory, or building, etc. (Specify) MAY 18 2004		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) STEPHEN R. STOUGH LAKE COUNTY AUDITOR		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT (Yes or no) 001492		

unit # 37
Key # 17-220-9
Glen Lane Add hot 9 Block 1
James Thomas
4133 Mississippi
Hobart, IN 46342



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MAY 18 2004

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CGL