Key # 29-41-10

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.

Local No. 12 5 8 - 04

34653

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEDENT—NAME (First Middle Last)	Betty Staples
2 SEX	Female
3a TIME OF DEATH	2:58 PM
3b DATE OF DEATH (Month Day Yr)	May 16, 2004
4 *SOCIAL SECURITY NUMBER	340-36-2282
5a AGE—Last Birthday (Years)	60
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	March 11,1944
7 BIRTHPLACE (City and State or Foreign Country)	Mattoon,IL
8a WAS DECEDENT A U S VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	None
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)	Riley Hospice Residence
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)	Theodore Staples
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	Caregiver
12b KIND OF BUSINESS/INDUSTRY	Healthcare
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Whiting
13d STREET AND NUMBER	1447 Fischrupp
13e ZIP CODE	46396
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+)	--

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Max Quattlander
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Clara Kovarnek

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Sally Stout
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2400 Harbor Blvd. #11 Port Charlotte,FL
20c Relationship	Sister

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)	May 21, 2004 Mt. Greenwood Cemetery
21c LOCATION—City or Town, State	Worth Township,IL
22a EMBALMER'S NAME	James Trolia
22b EMBALMER'S LICENSE NO	034-011898
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Thomas F. Burns (signature)
24b LICENSE NUMBER (of Licensee)	1045184
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN(For Beverly Ridge F.H./Chicago,IL Signature Only)

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.	Respiratory Distress	Minutes
DUE TO (OR AS A CONSEQUENCE OF): b.	Primary Pulmonary Carcinoid with mets to liver & spine	6-12 months
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

MAY 19 2004

Field	Entry
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)	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	Dr. P. Benchek (signature)
29c MEDICAL LICENSE NO	01045436
29d DATE SIGNED (Month Day Year)	5-17-04 May 17, 2004
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26)	Dr. P. Benchek 1534 119th St. Whiting, IN 46394

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	(signature)
32 DATE FILED (Month Day Year)	May 19, 2004

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

Theodore Staples 1447 Fischrupp Whiting, IN. 46394-2028