

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

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2987-04

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

RELATIVES

FORMANT

DISPOSITION

USE OF

Bankers Title

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) WILLIAM GENE CARPENTER				2. SEX MALE		3a. TIME OF DEATH 2:45 P.M.		3b. DATE OF DEATH (Month, Day, Yr.) DECEMBER 8, 2004	
4. SOCIAL SECURITY NUMBER 314-26-6474		5a. AGE—Last Birthday (Years) 71		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) NOVEMBER 3, 1933	
7a. WAS DECEDENT A U.S. VETERAN? YES		7b. YEAR LAST SERVED IN U.S. ARMED FORCES? UNAVAILABLE		7. BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA				8. 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	
9a. FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL				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) SHIRLEY ELAINE BENSON		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SALESMAN			12b. KIND OF BUSINESS/INDUSTRY RECREATIONAL		
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HIGHLAND			13d. STREET AND NUMBER 8942 WAYMOND STREET		
13e. ZIP CODE 46322		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? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+)			18. FATHER'S NAME (First, Middle, Last) SAMPSON REED CARPENTER				
19. MOTHER'S NAME (First, Middle, Maiden Surname) ANNETTA SHEPHARD					20a. INFORMANT'S NAME (Type/Print) SHIRLEY CARPENTER				
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8942 WAYMOND, HIGHLAND, INDIANA 46322					20c. Relationship WIFE				
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) DECEMBER 10, 2004			21c. LOCATION—City or Town, State NORTHWEST INDIANA CREMATION SERVICE CROWN POINT, INDIANA			
22a. EMBALMERS NAME NOT ENBALMED			22b. EMBALMERS LICENSE NO. N/A			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) FD20400030			25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PAGEN MILLER FUNERAL HOME FH83003035 2828 HIGHWAY AVENUE HIGHLAND, INDIANA 46322			
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Severe Pulmonary Fibrosis DUE TO (OR AS A CONSEQUENCE OF): b. Severe Pulmonary Hypertension 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. Severe LV dysfunction, Prior CABG									
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			
29. CERTIFIER (Check only one) <input 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.									
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29b. MEDICAL LICENSE NO. 01040607		29c. DATE SIGNED (Month, Day, Year) Dec 10, 2004	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. S. DIVAKARANI 9116 Columbia Ave, Munster, IN									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>									
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)		
34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)			34e. DESCRIBE HOW INJURY OCCURRED DEC 10 2004						
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.									

