8CCS

* **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

Local No. 2123-03 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 MTL- 3007LR04

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROSEMARY SARGENT
2. SEX: Female
3a. TIME OF DEATH: 3:30 AM M
3b. DATE OF DEATH (Month, Day, Yr.): September 7, 2003
4. *SOCIAL SECURITY NUMBER: 315-48-5144
5a. AGE—Last Birthday (Years): 86
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day. Yr): December 24, 1916
7. BIRTHPLACE (City and State or Foreign Country): Terre Haute 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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] 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): Widowed
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): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 906 W. 3rd Place
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): ; College (1-4 or 5 +): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): Harold Oscar Kelley
19. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Gorden

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jim Sargent
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 Scarborough, Apt. 12J, Chesterton, IN 46304
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Sep 9, 2003 Calvary Crematory
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

CAUSE OF DEATH

26. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events 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): Myocardial Infarction — Approximate Interval Between Onset and Death:
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last:
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
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): No

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: Milton Gasparis MD
29c. MEDICAL LICENSE NO: 01037515
29d. DATE SIGNED (Month, Day, Year): 9-9-03

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton Gasparis MD 1400 S. Lake Park Ave, Ste 301, Hobart, IN 46342
31. HEALTH OFFICER'S SIGNATURE: Susan J Best D.O.
32. DATE FILED (Month, Day, Year): September 9, 03

33. MANNER OF DEATH: [X] 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.)

FILED
JAN 20 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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