Key# 49-40-36

* 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. 238-05

# 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**

1. DECEASED - NAME (First, Middle, Last): Angie C. Petrick
2. SEX: Female
3a. TIME OF DEATH: 4:00 PM
3b. DATE OF DEATH (Month, Day, Yr.): January 18, 2005
4. *SOCIAL SECURITY NUMBER: 314-26-8900
5a. AGE - Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): July 09,1929
7. BIRTHPLACE (City and State or Foreign Country): Italy
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A

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): Lincolnshire Nursing Home
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Divorced
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Salesperson
12b. KIND OF BUSINESS/INDUSTRY: Sales
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 5964 W. 30 Avenue
13e. ZIP CODE: 46406
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?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE— American Indian, Black, White, etc. (Specify): Caucasian
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): Peter Catizone
19. MOTHER'S NAME (First, Middle, Maiden Surname): Patty (Maiden Name Unknown)

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Patricia Counts
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8610 E. 123rd Place Crown Point, IN 46307-
20c. Relationship: Daughter

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 22, 2005 Graceland Cemetery
21c. LOCATION - City or Town, State: Valparaiso, Indiana
22a. EMBALMER'S NAME: Donna S. Rippe
22b. EMBALMER'S LICENSE NO.: FD20100024
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD29600040
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bartholomew Funeral Home FH83006805 102 Monroe St. Valparaiso, Indiana 46383

**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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Resp Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. COPD
DUE TO (OR AS A CONSEQUENCE OF):
d. Pulmonary Fibrosis

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Ventilator dependent, Lung Cancer
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.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 1029936
29d. DATE SIGNED (Month, Day, Year): 1/25/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Oliver Crawford MD 4286 Broadway GARY IN. 46408

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Susan D. Burt DO
32. DATE FILED (Month, Day, Year): January 27, 2005

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? Specify driver, passenger, pedestrian, etc.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. JAN 27 2005

FILED JAN 28 2005 001474 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

9- XP cash

ATTN: SEND TO KENNETH D. HUDNALL 5935 W. 29TH AVE GARY, IN 46406

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