

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

COMMUNITY TITLE COMPANY

FILE NO L 31207

CERTIFICATE OF DEATH

State No.

Local No. 0099-05

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

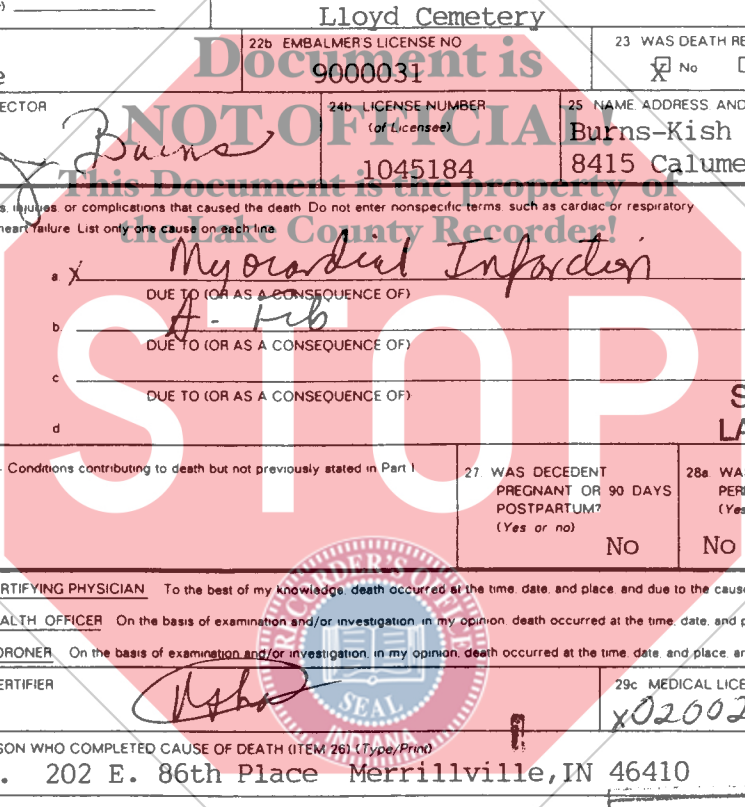
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle, Last) Dorothy Brown				2 SEX Female		3a TIME OF DEATH 1:40P M		3b DATE OF DEATH (Month, Day, Yr) January 12, 2005							
4 *SOCIAL SECURITY NUMBER -		5a AGE—Last Birthday (Years) 88		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo Day Yr) Oct. 20, 1916		7 BIRTHPLACE (City and State or Foreign Country) Damascus Arkansas					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> 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) 51 <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) Widowed		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) Homemaker				12b KIND OF BUSINESS/INDUSTRY Home							
13a RESIDENCE—STATE IN		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hobart			13d STREET AND NUMBER 6140 Avocet Circle								
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+) 12			
18 FATHER'S NAME (First, Middle, Last) Irvin Hutto						19 MOTHER'S NAME (First, Middle, Maiden Surname) Annie Cook									
20a INFORMANT'S NAME (Type/Print) Elizabeth Evans				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6138 Avocet Circle Hobart, IN 46342				20c Relationship Daughter							
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) January 17, 2005 Lloyd Cemetery				21c LOCATION—City or Town, State Damascus, Arkansas							
22a EMBALMER'S NAME John T. Noble				22b EMBALMER'S LICENSE NO. 9000031		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes									
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas Burns</i>				24b LICENSE NUMBER (of Licensee) 1045184		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Ave. Munster, IN 46321									
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. Myocardial Infarction A - Fib										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) ---	
IMMEDIATE CAUSE (Final disease or condition resulting in death) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) A - Fib										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH JUN - 2 2005					
CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST										STEPHEN R. STIGLICH LAKE COUNTY AUDITOR					
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) ---	
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>Susan W. Best, D.O.</i>				29c MEDICAL LICENSE NO. x02002106		29d DATE SIGNED (Month, Day, Year) Jan. 14, 2005							
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) R. Shah, M.D. 202 E. 86th Place Merrillville, IN 46410															
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</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 LOCATION (Street and Number or Rural Route Number, City or Town, State) JAN 14 2005							
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 00228													



FILED

JUN - 2 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPT.
JAN 14 2005