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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

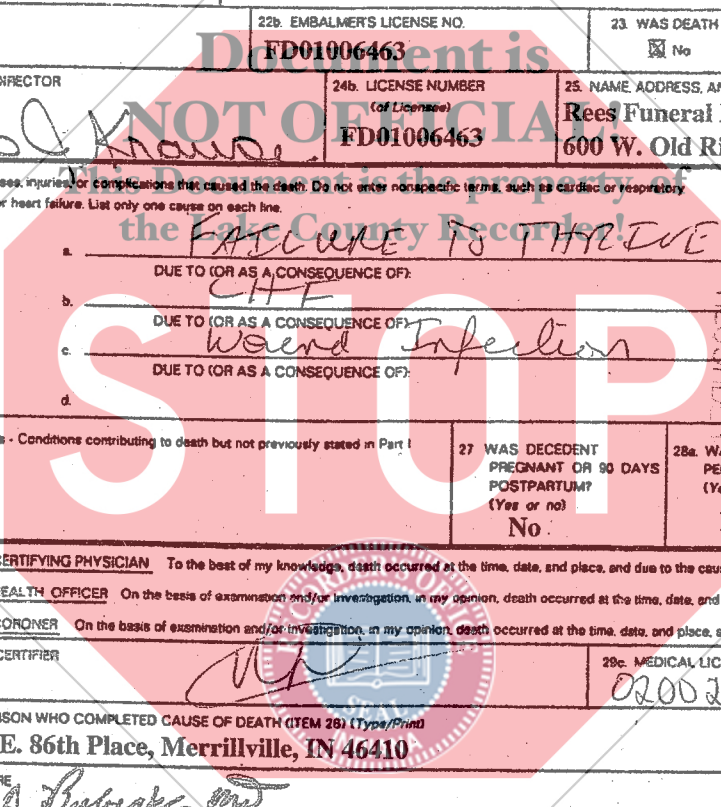
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) MURIEL L. KOONSMAN		2. SEX Female	3a. TIME OF DEATH 12:18 AM	3b. DATE OF DEATH (Month, Day, Yr.) October 16, 2003	
4. SOCIAL SECURITY NUMBER 317-09-7346	5a. AGE—Last Birthday (Years) 103	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) May 7, 1900	
7a. WAS DECEDENT A U.S. VETERAN? No	7b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	7. BIRTHPLACE (City and State or Foreign Country) Princeton Kentucky			
8a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
9a. FACILITY NAME (If not institution, give street and number) VNA Hospice Center		9b. CITY, TOWN, OR LOCATION OF DEATH Valparaiso		9c. COUNTY OF DEATH Porter	
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 4094 Howard Street	
13e. ZIP CODE 46342	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 2005 College (1-4 or 5+) 7		18. FATHER'S NAME (First, Middle, Last) Samuel A. Utley			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Olive T. Howton		20a. INFORMANT'S NAME (Type/Print) James Mason			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 N 600 W, Valparaiso, IN 46385		20c. Relationship Grandson			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) Oct 20, 2003 Evergreen Memorial Park		21c. LOCATION—City or Town, State Hobart IN	
22a. EMBALMER'S NAME: James J. Krause		22b. EMBALMER'S LICENSE NO. FD01006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of License) FD01006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) FAILURE TO THRIVE					
a. DUE TO (OR AS A CONSEQUENCE OF): CHF					
b. DUE TO (OR AS A CONSEQUENCE OF): Wound Infection					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. 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	
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>[Signature]</i>		29c. MEDICAL LICENSE NO. 02002166	29d. DATE SIGNED (Month, Day, Year) 10/17/03		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) R. Shah MD 202 E. 86th Place, Merrillville, IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) October 17, 2003		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.			

(217) 17-0064-0004 Charles M Barney's Gary Park Add S. 136.10 ft lot 4 Block 3



2005 JUN - 8 AM 5:19 FILED FOR RECORDS

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Handwritten initials and date: 9-17-03