

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

Key #

12-25-8

CERTIFICATE OF DEATH

State No.

Local No. 270-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

167051
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Edna Ruth Huntington				2. SEX Female		3a. TIME OF DEATH 1:40A		3b. DATE OF DEATH (Month, Day, Yr.) February 6, 2001	
4. *SOCIAL SECURITY NUMBER 315-10-3138		5a. AGE—Last Birthday (Years) 81		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) July 13, 1919	
7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		8a. WAS DECEDENT A U.S. VETERAN? No							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
9b. FACILITY NAME (If not institution, give street and number) 9461 White Oak				9c. CITY, TOWN OR LOCATION OF DEATH St. John		9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Harold Huntington		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 At Home			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION St. John		13d. STREET AND NUMBER 9461 White Oak			
13e. ZIP CODE 46373		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	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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) Archie Mills				19. MOTHER'S NAME (First, Middle, Maiden Surname) Naomi Anderson	
20a. INFORMANT'S NAME (Type/Print) Harold Huntington				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9461 White Oak St. John, IN 46373				20c. Relationship Husband	
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) February 9, 2001 Regional Cremation				21c. LOCATION—City or Town, State Munster, Indiana			
22a. EMBALMER'S NAME James F. Betkowski				22b. EMBALMER'S LICENSE NO. FD09200077		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Betkowski</i>				24b. LICENSE NUMBER (of Licensee) FD09200077		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Elmwood Chapel FHD# 19900052 11300 W. 97th Lane St. John, Indiana 46373			
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. Advance of ovarian carcinoma IMMEDIATE CAUSE (Final disease or condition resulting in death) THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE STATEMENT OF THE CAUSE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. a. DUE TO (OR AS A CONSEQUENCE OF): b. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause, if any: JUN 16 2005 c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
26. 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)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) STEPHEN R. STIGLITZ LAKE COUNTY AUDITOR		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>M. Ali</i>						29c. MEDICAL LICENSE NO. 29782		29d. DATE SIGNED (Month, Day, Year) 2-6-01	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. M. Ali 1630 45th Ave. Munster, Indiana 46321									
31. HEALTH OFFICER'S SIGNATURE <i>Samuel L. Fortson</i>								32. DATE FILED (Month, Day, Year) February 6, 2001	
33. MANNER OF DEATH <input 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 001405			
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) 9- LP CS				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						