ATTENTION ESTATE: The Social Security # is eing requested by this state agency in order to ursue its statutory responsibility. Disclosure is oluntary and there will be no penalty for refusal.

Local No. 3191-04

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): EVELYN RICH
2. SEX: FEMALE
3a. TIME OF DEATH: 10:58 PM
3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 27, 2004
4. *SOCIAL SECURITY NUMBER: 314-20-0052
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): May 19, 1926
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?: 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): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Adrian J. Rich
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Owner/Operator
12b. KIND OF BUSINESS/INDUSTRY: Daycare
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond,
13d. STREET AND NUMBER: 6539 Marsha
13e. ZIP CODE: 46323
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): 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): Gilbert Thomas Neil
19. MOTHER'S NAME (First, Middle, Maiden Surname): Elza Nodley

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Tom Rich
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6539 Marshall, Hammond, IN 46323
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 3, 2005 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Jose Corona
22b. EMBALMER'S LICENSE NO: FD08601373
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD08600181
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn Funeral Home #19900051 8178 Cline Ave., Schererville, IN 463

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. JAN 04 2005 Acute Hemodynamic collapse	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Recent Acute Myocardial infarction	
	c. DUE TO (OR AS A CONSEQUENCE OF): Severe Mitral Regurgitation	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Severe Native Coronary Artery disease; Prior Aorto Coronary bypass Congestive Heart Failure; Renal Insufficiency; arteriosclerotic cardiomyopathy

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no):
28a. WAS AN AUTOPSY PERFORMED? (Yes or no):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Shashidhar Div (Cama MD)
29c. MEDICAL LICENSE NO: 01040667A
29d. DATE SIGNED (Month, Day, Year): DECEMBER 29th 2004
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SHASHIDHAR DIVAKARUNI, M.D. 9116 COLUMBIA AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Burt D.O.
32. DATE FILED (Month, Day, Year): JANUARY 4, 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? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: 1515

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