

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

CERTIFICATE OF DEATH

State No.

Local No. 191-03

#443655 THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

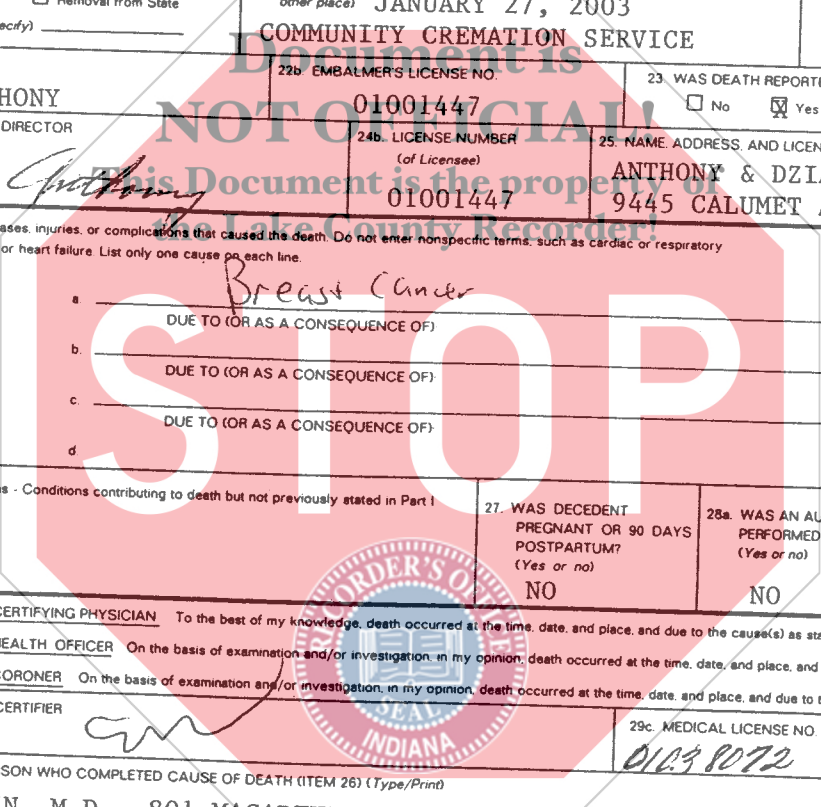
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) BARBARA ANN HARVEY				2. SEX FEMALE		3a. TIME OF DEATH 3:00 A.M.		3b. DATE OF DEATH (Month, Day, Year) JANUARY 23, 2003	
4. *SOCIAL SECURITY NUMBER 341-44-5164		5a. AGE—Last Birthday (Years) 52		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) JUNE 6, 1950	
7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS		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.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify) HOSPICE RESIDENCE			
9b. FACILITY NAME (If not institution, give street and number) 511 OTIS BOWEN DRIVE				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) RICHARD W. HARVEY		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SCHOOL TEACHER		12b. KIND OF BUSINESS/INDUSTRY ELEMENTARY SCHOOL			
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION MUNSTER		13d. STREET AND NUMBER 1815 ORIOLE DRIVE			
13e. ZIP CODE 46321		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+		18. FATHER'S NAME (First, Middle, Last) RAYMOND L. HEMESATH				19. MOTHER'S NAME (First, Middle, Maiden Surname) MAE C. LARSON			
20a. INFORMANT'S NAME (Type/Print) RICHARD W. HARVEY				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 ORIOLE DR, MUNSTER, IN 46321				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) JANUARY 27, 2003 COMMUNITY CREMATION SERVICE				21c. LOCATION—City or Town, State SCHERERVILLE, INDIANA	
22a. EMBALMER'S NAME LARRY D. ANTHONY				22b. EMBALMER'S LICENSE NO. 01001447		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>				24b. LICENSE NUMBER (of licensee) 01001447		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ F.H. #83002916 9445 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Breast Cancer DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Approximate Interval Between Onset and Death Year									
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. 01038072		29d. DATE SIGNED (Month, Day, Year) JANUARY 24, 2003	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ERWIN L. ROBIN, M.D., 801 MAGARTHUR, MUNSTER, INDIANA 46321									
31. HEALTH OFFICER'S SIGNATURE <i>Susan J But SO.</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. DESCRIBE HOW INJURY OCCURRED JUN 6 2005			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.						



THIS CERTIFIES THE ARRIVAL AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT