

1054500714

Key No. 13-472-11

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

Local No. 3049-04
33061

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

TYPE/PRINT IN PERMANENT BLACK INK

PRECEDENT

PARENTS

INFORMANT

DISPOSITION

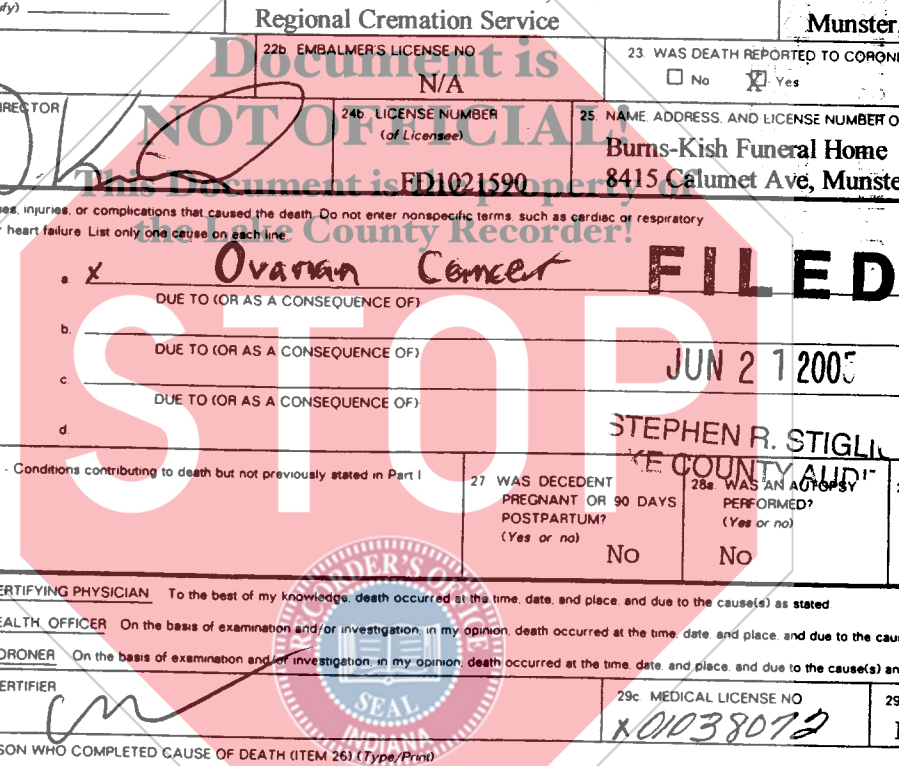
CAUSE OF DEATH

Stewart Title Services of Northwest Indiana
The Pointe
5521 W. Lincoln Hwy.
Crown Point, IN 46307

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Donna J. Walton				2 SEX Female	3a TIME OF DEATH 6:09 pm_M	3b DATE OF DEATH (Month, Day, Yr) December 15, 2004	
4 *SOCIAL SECURITY NUMBER 306-36-8440	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) January 29, 1935	7 BIRTHPLACE (City and State or Foreign Country) Hammond, IN		
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 type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) 114 St. Andrews Dr.			9c CITY, TOWN, OR LOCATION OF DEATH Schererville		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 Own Home			
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Schererville		13d STREET AND NUMBER 114 St. Andrews Dr.			
13e ZIP CODE 46375	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) 4 College (1-4 or 5+) 4	
18 FATHER'S NAME (First, Middle, Last) Delmar Williams			19 MOTHER'S NAME (First, Middle, Maiden Surname) Madge Bailey				
20a INFORMANT'S NAME (Type/Print) Debra Gaddy			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5623 Ravenna Ct., San Jose, CA 95118		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) December 17, 2004 Regional Cremation Service		21c LOCATION—City or Town, State Munster, IN			
22a EMBALMER'S NAME N/A		22b EMBALMER'S LICENSE NO. N/A		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) FD1021590		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home Lic # 3004968 8415 Calumet Ave, Munster, IN 46321-2521			
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) x Ovarian Cancer DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) 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)			
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 X 		29c MEDICAL LICENSE NO. X 01038072		29d DATE SIGNED (Month, Day, Year) Dec. 17, 2004	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) E. Robin, M.D. 801 MacArthur Blvd. Munster, IN 46321							
31 HEALTH OFFICER'S SIGNATURE E. Robin, M.D.							
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 DEC 17 2004		
		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. 01709					



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