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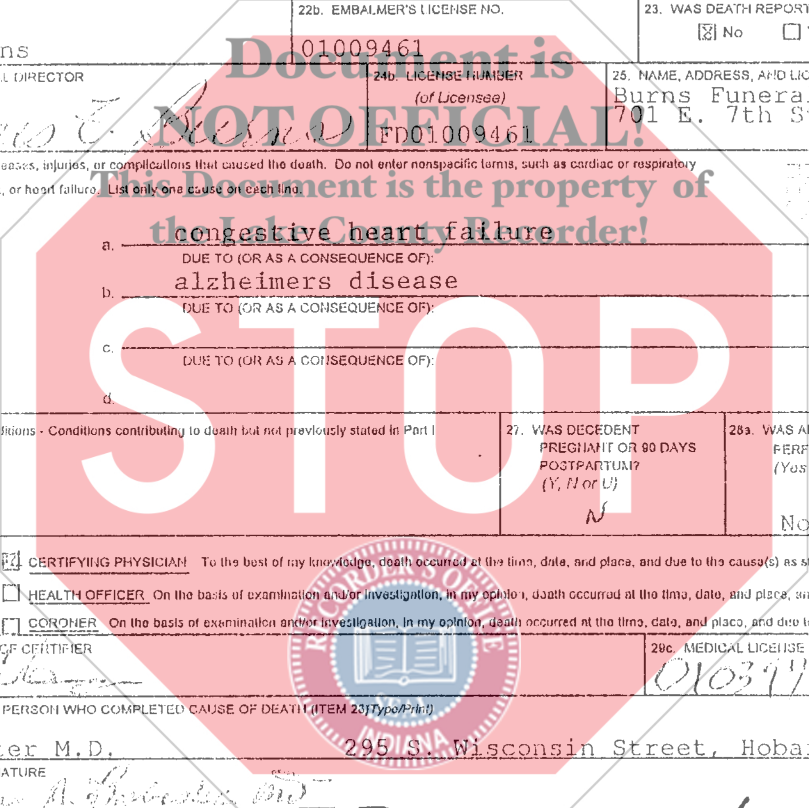
PORTER COUNTY
CERTIFICATE OF DEATH

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

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

TYPE/PRINT IN PERMANENT BLACK INK



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DECEDENT

1. DECEASED - NAME (First, Middle, Last): Carol M Storey
2. SEX: Female
3a. TIME OF DEATH: 12:55 PM
3b. DATE OF DEATH (Month, Day, Yr.): May 14, 2005
4. SOCIAL SECURITY NUMBER: 306-09-5985
5a. AGE - Last Birthday (Years): 89
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): August 01, 1915
7. BIRTHPLACE (City and State or Foreign Country): Hobart Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: —
PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Fountainview Place Nursing Home
9c. CITY, TOWN, OR LOCATION OF DEATH: Portage
9d. 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.): Secretarial
12b. KIND OF BUSINESS/INDUSTRY: NIPSCO
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 714 Water St.
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 12; College (1-4 or 5+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): Frank Smith
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Kisela

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ronald Smith
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2218 Samuelson Rd, Portage, IN 46368
20c. Relationship: Nephew

2005 053620

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 18, 2005 Hobart Cemetery
21c. LOCATION - City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: James F. Burns
22b. EMBALMER'S LICENSE NO.: 01009461
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342

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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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. alzheimers disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U): N
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): —

CERTIFIER

29a. CERTIFIER (Check only one)
☒ 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: [signature]
29c. MEDICAL LICENSE NO.: 01039953
29d. DATE SIGNED (Month, Day, Year): 5/16/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23)(Type/Print): John E. Carter M.D. 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): [handwritten]
33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): May 14, 2005
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED JUN 29 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

FILED JUN 23 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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(27) 17-0139-0005
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