

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH COUNTY State No.

Local No. 1704-05

FILED FOR RECORD

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

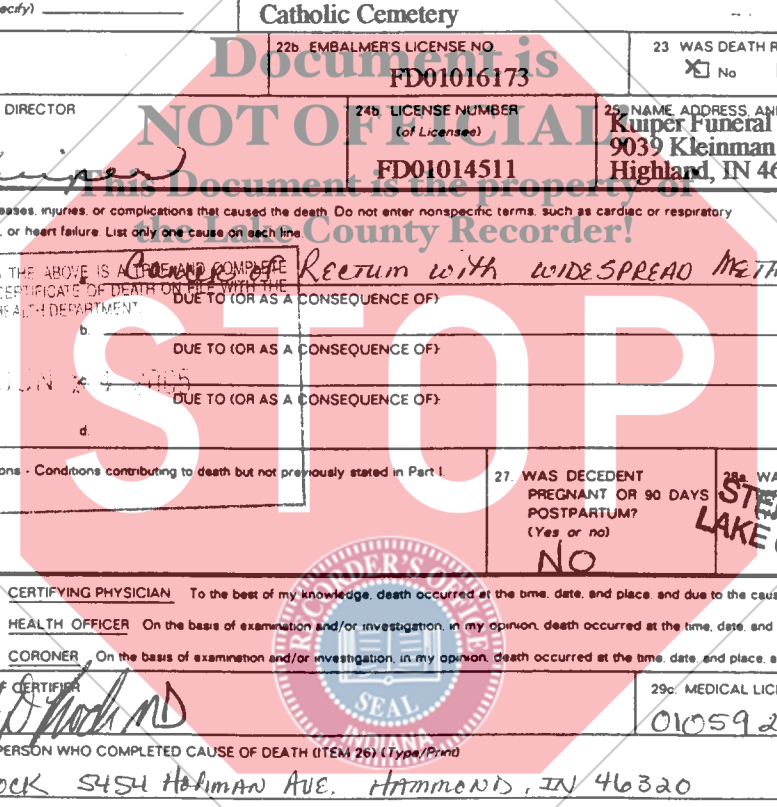
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Elizabeth "Betty" D. Breger				2 SEX Female		3a. TIME OF DEATH 10:42 am		3b. DATE OF DEATH (Month, Day, Yr.) June 21, 2005	
4. *SOCIAL SECURITY NUMBER 314-26-9347		5a. AGE—Last Birthday (Years) 74		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) June 18, 1931	
7a. WAS DECEASENT A U.S. VETERAN? No		7b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8a. 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"/> Residence				7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	
9b. FACILITY NAME (If not institution, give street and number) 3005-99th Place West				9c. CITY, TOWN, OR LOCATION OF DEATH Highland			9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) William B. Breger		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 Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Highland			13d. STREET AND NUMBER 3005 99th Place West		
13e. ZIP CODE 46322		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEASENT 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) 12		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) William Tyler			19. MOTHER'S NAME (First, Middle, Maiden Surname) Estella Stiglitz		
20a. INFORMANT'S NAME (Type/Print) William B. Breger				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 99th Place West, Highland, IN 46322				20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) June 25, 2005 Catholic Cemetery				21c. LOCATION—City or Town, State Hammond, Indiana	
22a. EMBALMER'S NAME Edgar Gleim				22b. EMBALMER'S LICENSE NO. FD01016173		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>C.A. Kuiper</i>				24b. LICENSE NUMBER (of Licensee) FD01014511		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Road Highland, IN 46322 FH10300021			
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 (PART I) 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) Rectum with WIDESPREAD METASTASES b. DUE TO (OR AS A CONSEQUENCE OF) Rectum with WIDESPREAD METASTASES c. DUE TO (OR AS A CONSEQUENCE OF) Rectum with WIDESPREAD METASTASES d. DUE TO (OR AS A CONSEQUENCE OF) Rectum with WIDESPREAD METASTASES PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I.									
27. WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No				28. WAS AN AUTOPSY PERFORMED? No		29. 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>Robert D. Prock</i>						29c. MEDICAL LICENSE NO. 01059232A		29d. DATE SIGNED (Month, Day, Year) 6/22/05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. ROBERT PROCK 5454 HOLMAN AVE. HAMMOND, IN 46320									
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best D.O.</i>							32. DATE FILED (Month, Day, Year) June 24, 2005		
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		
34a. 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. 112807					



FILED JUL 7 5 2005 STEPHEN R. STIGLITZ LAKE COUNTY AUDITOR

Handwritten initials and signatures: AS, Goo, JM.