

5cc 2

* ATTENTION STATE: 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.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

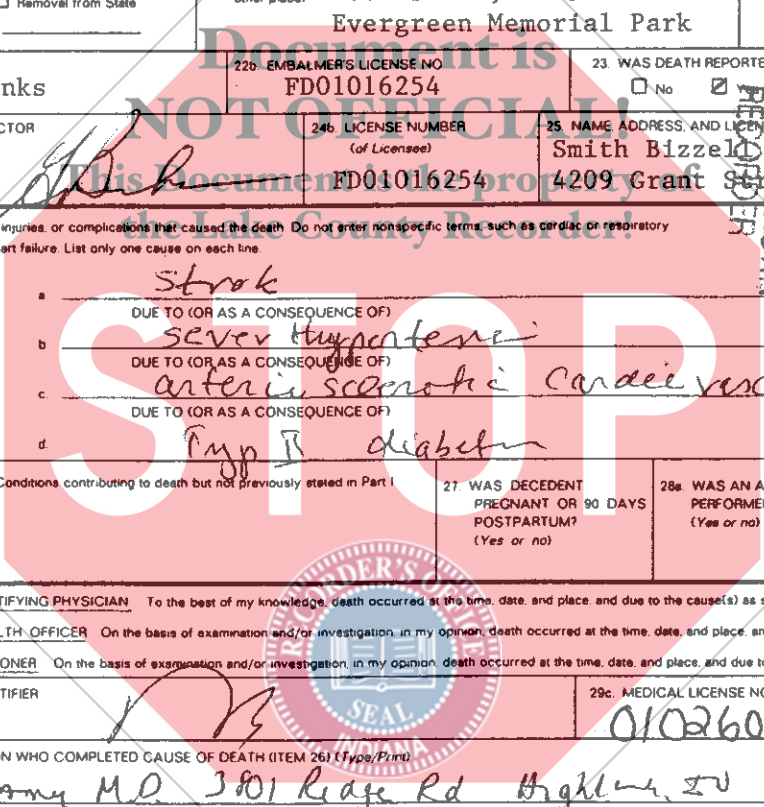
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Odessa B. Moss		2 SEX Female		3a. TIME OF DEATH 8:05 A M		3b. DATE OF DEATH (Month, Day, Yr) October 26, 2005	
4. *SOCIAL SECURITY NUMBER		5a. AGE—Last Birthday (Years)		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) September 9, 1928		7. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri					
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: <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) 578 Broadway Apt 320				9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widow		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) Home Maker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 578 Broadway Apt 320	
13e. ZIP CODE 46402		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A		15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. RACE—American Indian, Black, White, etc. (Specify) Black		17. DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 11 College (1-4 or 5+) <input type="checkbox"/>					
18. FATHER'S NAME (First Middle Last) (Unavailable)				19. MOTHER'S NAME (First Middle, Maiden Surname) Modene Collins			
20a. INFORMANT'S NAME (Type/Print) Robert Moss				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 East 140th Pl. East Chicago, IN 46312		20c. Relationship 2 Son	
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) November 1, 2005 Evergreen Memorial Park			21c. LOCATION—City or Town, State Hobart Indiana		
22a. EMBALMER'S NAME Sherman G. Banks		22b. EMBALMER'S LICENSE NO. FD01016254		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) FD01016254		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzelo & Warder 4209 Grant Street Gary, Indiana 46408			
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. <u>stroke</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>severe hypertension</u> DUE TO (OR AS A CONSEQUENCE OF) c. <u>arteriosclerotic cardiac vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF) d. <u>type II diabetes</u> 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)		28a. WAS AN AUTOPSY PERFORMED? (Yes or 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				29c. MEDICAL LICENSE NO. 01026043		29d. DATE SIGNED (Month, Day, Year) 11/7/05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) M.A. Rahmany M.D. 3801 Ridge Rd Highland, IN 46322							
31. HEALTH OFFICER'S SIGNATURE						32. DATE FILED (Month, Day, Year) NOV 28 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) FEB 06 2006		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. PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR			



Vertical stamp: STATE OF INDIANA LAKE COUNTY FILED FOR RECORD NOV 28 AM 11:25

FILED FEB 06 2006

002474

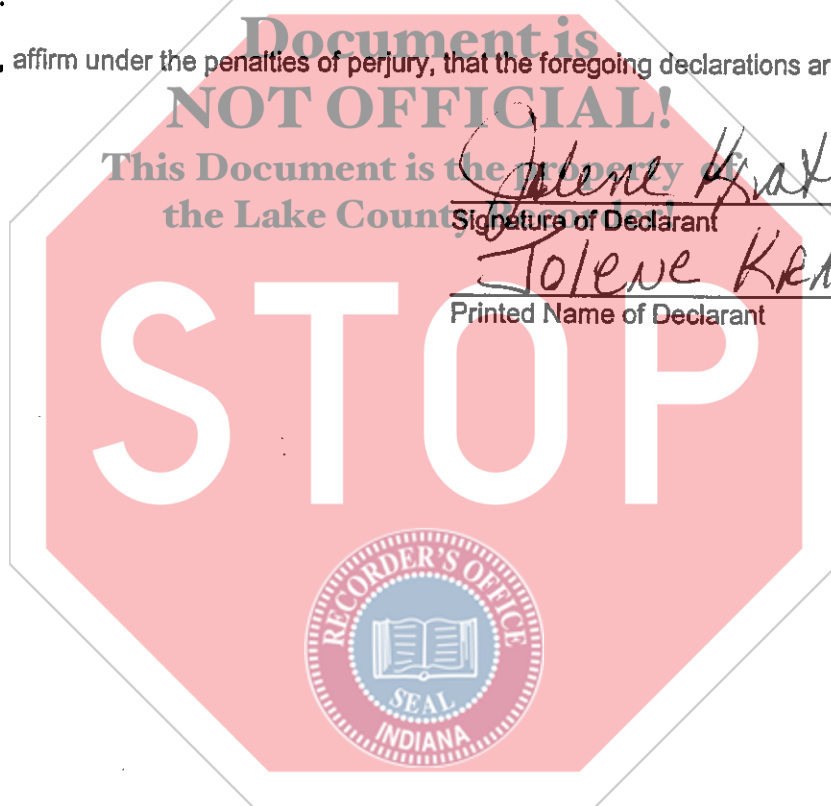
Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security numbers;
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, the undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.



→ Indian Network