

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. 1912-63

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

86339
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Mary Blom		2. SEX Female	3a. TIME OF DEATH 6:39A M	3b. DATE OF DEATH (Month, Day, Yr) August 10, 2003	
4. *SOCIAL SECURITY NUMBER [REDACTED]-5411	5a. AGE—Last Birthday (Years) 65	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) Aug. 30, 1937	
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 checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) Community Hospital		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) Dennis Blom	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sales Clerk		12b. KIND OF BUSINESS/INDUSTRY Retail	
13a. RESIDENCE—STATE IN	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Highland	13d. STREET AND NUMBER 2343 99th St. Unit 1B		
13e. ZIP CODE 46322	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12 College (1-4 or 5+) ---			
18. FATHER'S NAME (First, Middle, Last) Jack Jeffries		19. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Cary			
20a. INFORMANT'S NAME (Type/Print) Dennis Blom		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2343 99th St. Unit 1B Highland, IN 46322		20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) August 14, 2003 Elmwood Cemetery		21c. LOCATION—City or Town, State Hammond, IN	
22a. EMBALMER'S NAME Brian T. Burns		22b. EMBALMER'S LICENSE NO. 8601763	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1021590	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3007968 8415 Calumet 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) Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF) 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 DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
27. WAS DECEASED 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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01031764	29d. DATE SIGNED (Month, Day, Year) Aug. 11, 2003		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) P. Makam, M.D. 9126 Columbia Ave. Munster, IN 46321					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) Aug 12, 2003	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY WORK? Yes or No	34d. DESCRIBE HOW INJURY OCCURRED FILED AUG - 3 2006 1102 CT R
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) NO			