Re-sub

*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.

2CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILED FOR RECORD

2006 AUG 10 PM 3:18

Local No. 00-0171

State No.

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2006 069685

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Junetta Heffner
2. SEX: Female
3a. TIME OF DEATH: 6:55 A M
3b. DATE OF DEATH (Month Day Yr): February 25, 2000
4. *SOCIAL SECURITY NUMBER: 306-44-3047
5a. AGE—Last Birthday (Years): 60
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): August 6, 1939
7. BIRTHPLACE (City and State or Foreign Country): Owensboro, Kentucky
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: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Divorced
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): Office Clerk
12b. KIND OF BUSINESS/INDUSTRY: Red Cross
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4800 Madison Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): XX No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):

PARENTS

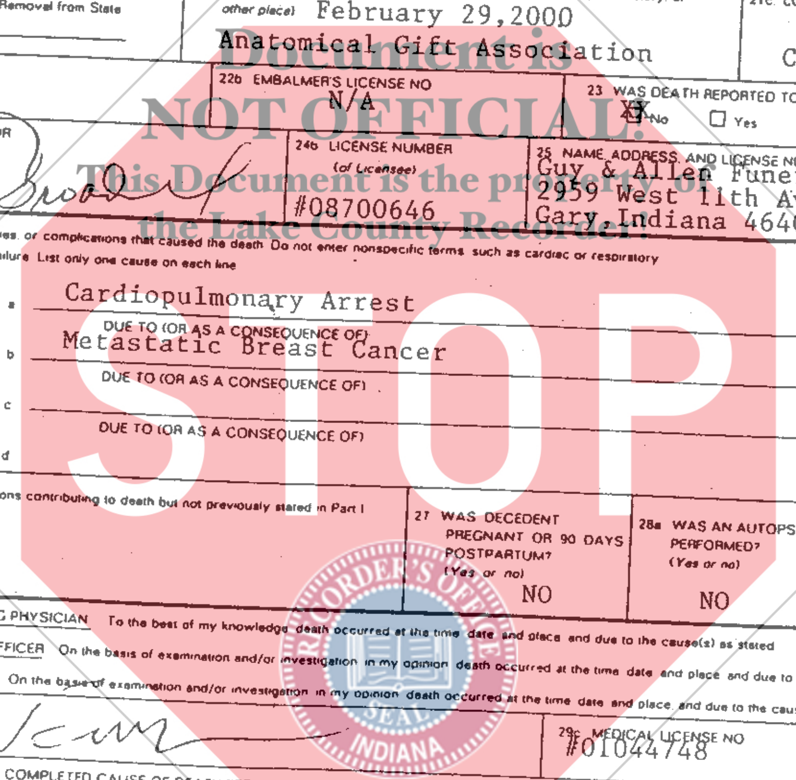
18. FATHER'S NAME (First, Middle, Last): John Howard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Eula Danzy

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Chris Heffner
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4800 Madison Street Gary, Indiana 46408
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Entombment ☐ Removal from State XXX Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 29, 2000 Anatomical Gift Association
21c. LOCATION—City or Town, State: Chicago, Illinois
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700646
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704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RECORDER'S OFFICE SEAL INDIANA

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Cardiopulmonary Arrest	
b DUE TO (OR AS A CONSEQUENCE OF)	Metastatic Breast Cancer	1996
c DUE TO (OR AS A CONSEQUENCE OF)		
d 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 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):

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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: #01044748
29d. DATE SIGNED (Month, Day, Year): 4/15/00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print): Dr. Dauphin 3229 Broadway Gary, Indiana 46408
31. HEALTH OFFICER'S SIGNATURE: [signature] MD, MPH
32. DATE FILED (Month, Day, Year): APR 13 2000

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):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.