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

Local No. 0206-06

State No. 28-29-0040-0023

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): VIOLET REGAN
2. SEX: FEMALE
3a. TIME OF DEATH: 9:59A M
3b. DATE OF DEATH (Month, Day, Yr.): JAN 24, 2006
4. *SOCIAL SECURITY NUMBER: 304-38-9225
5a. AGE—Last Birthday (Years): 94
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo. Day, Yr.): AUGUST 22, 1911
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO IN
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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] 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): WIDOW
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): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: IN
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING
13d. STREET AND NUMBER: 1836 SHERIDAN
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): FRED ACKER
19. MOTHER'S NAME (First, Middle, Maiden Surname): ALLIE COUNCILMAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JANE DAVENPORT
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1833 SHERIDAN WHITING IN 46394
20c. Relationship: DAUGHTER

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 30, 2006 REGIONAL CREMATORY
21c. LOCATION—City or Town, State: MUNSTER IN
22a. EMBALMER'S NAME: THOMAS OWENS
22b. EMBALMER'S LICENSE NO.: 1001049
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thos Owens
24b. LICENSE NUMBER (of Licensee): 1001049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: OWENS C.H. 816 119TH Whiting IN 46394 3007291

FILED 2006 AUG 22 AM 11:33 MICHAEL BROWN RECORDER

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. SEPSIS — Approximate Interval Between Onset and Death: 48 hrs
DUE TO (OR AS A CONSEQUENCE OF):
b. CELLULITIS LEGS — 2 weeks
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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: DEMENTIA

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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):
[ ] 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: John Dwyer MD
29c. MEDICAL LICENSE NO.:
29d. DATE SIGNED (Month, Day, Year): Jan 24, 06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 1929 Ridge Road, Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan FILED

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. AUG 30, 2006

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: AUG 21 2006
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY occurred: JAN 30 2006 11:02
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1600 C3
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

SDH06-004 State Form 10110 (R5/1-99)