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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

06-16-0004-0018

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) LAVENIA J. HOSKINS				2. SEX Female		3a. TIME OF DEATH 9:51 PM		3b. DATE OF DEATH (Month, Day, Year) July 30, 2006	
4. SOCIAL SECURITY NUMBER 407-46-9959		5a. AGE—Last Birthday (Years) 70	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) October 1, 1935		7. BIRTHPLACE (City and State or Foreign Country) Hopkins County 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: <input checked="" type="checkbox"/> Inpatient <input 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) Porter - Portage Campus				9c. CITY, TOWN, OR LOCATION OF DEATH Portage		9d. COUNTY OF DEATH Porter			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Everett Hoskins		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cafeteria			12b. KIND OF BUSINESS/INDUSTRY School		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hobart		13d. STREET AND NUMBER 1443 E 31st. Ave.			
13e. ZIP CODE 46342	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 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 (9-12) 10 College (1-4 or 5+) 06		
18. FATHER'S NAME (First, Middle, Last) Jessie L. Moore				19. MOTHER'S NAME (First, Middle, Maiden Surname) Gurtrude Oldham					
20a. INFORMANT'S NAME (Type/Print) Everett S. Hoskins				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1443 E. 32st. Ave, Hobart, IN 46342				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) Aug 4, 2006 Evergreen Memorial Park			21c. LOCATION—City or Town, State Hobart IN			
22a. EMBALMER'S NAME James J. Krause			22b. EMBALMER'S LICENSE NO. FD01006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>			24b. LICENSE NUMBER (of Licenses) FD01006463		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488				
26. PART I. Enter the disease, 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. Aspiration Pneumonitis. DUE TO (OR AS A CONSEQUENCE OF): b. Recurrent Aspiration 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				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) 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. 01039880		29d. DATE SIGNED (Month, Day, Year) 8/19/06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) S. Patel MD 1140 S. Calumet Avenue, Ste 2., Chesterton, IN 46304									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>							32. DATE FILED (Month, Day, Year) August 18, 2006		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) AUG 25 2006				
34e. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) LAKE COUNTY AUDITOR							

FILED FOR RECORDED
MICHAEL LEWIS
2006 AUG 25 AM 11:34
CLERK OF INDIANA
DEPT OF HEALTH
INDY COUNTY
RECORDS

FILED
AUG 25 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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