

\* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

May 3, 2007  
Date Issued  
Hammond Health Commissioner

Local No. 279

State No.

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) <b>Aline Oberc</b>		2. SEX <b>Female</b>		3a. TIME OF DEATH <b>3:30AM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>May 3, 2007</b>	
4. *SOCIAL SECURITY NUMBER <b>306-34-6166</b>		5a. AGE—Last Birthday (Years) <b>72</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) <b>Sept. 12, 1934</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>N/A, Kentucky</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>NONE</b>		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) <b>6269 Delaware St.</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Hammond</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Alfred</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Owner/Operator</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Day Care</b>	
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Hammond</b>		13d. STREET AND NUMBER <b>6269 Delaware St.</b>	
13e. ZIP CODE <b>46323</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>					
18. FATHER'S NAME (First, Middle, Last) <b>Virgil Geary</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lueticia Phelps</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Alfred Oberc</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6269 Delaware St. Hammond, IN. 46323</b>		20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>May 5, 2007 Regional Cremation Service</b>		21c. LOCATION—City or Town, State <b>Munster, IN</b>			
22a. EMBALMER'S NAME <b>N.A.</b>		22b. EMBALMER'S LICENSE NO. <b>NONE</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>1021590</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>White Funeral Home PH00600026 921 W. 45th St. Griffith, IN.</b>			
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. <b>Renal cell carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ 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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>			
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. <b>33507</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-3-07</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Howard Mishoulam 6054 Columbia Ave. Munster, IN. 46321</b>							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) <b>May 3, 2007</b>	
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)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW INJURY OCCURRED <b>006433</b>		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.			



FILED  
MAY 16 2007  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR