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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. 1881-01

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) BARBARA J. ELLIS				2 SEX FEMALE		3a TIME OF DEATH 10:45A.M.		3b DATE OF DEATH (Month, Day, Yr.) AUGUST 22, 2001							
4 *SOCIAL SECURITY NUMBER 312- <del>XXXX</del>		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.) Nov. 8, 1935		7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana					
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) THE 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) Jim Ellis			12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker			12b KIND OF BUSINESS/INDUSTRY Own Home							
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Highland			13d STREET AND NUMBER 9043 Hess Dr.								
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) <u>HS</u> College (1-4 or 5 +)			
18 FATHER'S NAME (First, Middle, Last) Barney Walczak						19 MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Glowacki									
20a INFORMANT'S NAME (Type/Print) James Ellis				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State (Zip Code)) 9043 Hess Dr., Highland, Indiana 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 25, 2001 Chapel Lawn Cemetery				21c LOCATION—City or Town, State Scherverville, Indiana							
22a EMBALMER'S NAME Edgar C. Gleim				22b EMBALMER'S LICENSE NO. FDO 1016173		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes									
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. L...</i>				24b LICENSE NUMBER (of Licensee) FDO 1010850		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 19900008									
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) Hypotensive Shock Sepsis DUE TO (OR AS A CONSEQUENCE OF) Severe Venous Thrombosis Disseminated Intravascular Coagulation Severe Pulmonary Embolism Diabetes Mellitus, Hypertension, Central Venous Catheter CONDITIONS CONTRIBUTING TO DEATH BUT NOT PREVIOUSLY LISTED IN PART I WAS DECEDENT PREGNANT OR 90-DAYS POSTPARTUM? (Yes or no) LAKE COUNTY AUDITOR										Approximate Interval Between Onset and Death					
27 PART II. Other significant conditions contributing to death but not previously listed in Part I										28a WAS AN AUTOPSY PERFORMED? LAKE COUNTY AUDITOR		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/>			
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>Deanna Port-Keene</i>		29c MEDICAL LICENSE NO. 01029185		29d DATE SIGNED (Month, Day, Year) AUGUST 23 2001	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DEANNA L. PORT-KEENE, M.D., 1650 45TH STREET, MUNSTER, INDIANA 46321										31 HEALTH OFFICER'S SIGNATURE <i>Susan W. East, D.O.</i>		32—DATE FILED (Month, Day, Year) August 24, 2001			
33 MANNER OF DEATH <input 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 DESCRIBE HOW INJURY OCCURRED 11-4P 21293 CT							
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.					

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