

\* 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

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

Local No. 60

CERTIFICATE OF DEATH

Jan 31, 2006 Date Issued Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

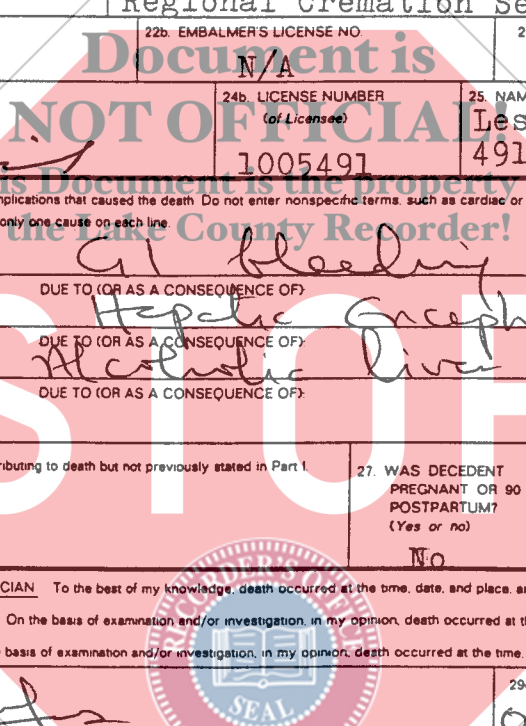
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Form with fields for DECEASED-NAME, SEX, TIME OF DEATH, SOCIAL SECURITY NUMBER, AGE, DATE OF BIRTH, BIRTHPLACE, FACILITY NAME, MARRITAL STATUS, SURVIVING SPOUSE, DECEASED'S USUAL OCCUPATION, RESIDENCE, CITIZEN OF WHAT COUNTRY, RACE, DECEASED'S EDUCATION, FATHER'S NAME, MOTHER'S NAME, INFORMANT'S NAME, MAILING ADDRESS, RELATIONSHIP, METHOD OF DISPOSITION, DATE AND PLACE OF DISPOSITION, LOCATION, EMBALMER'S NAME, LICENSE NO, WAS DEATH REPORTED TO CORONER, SIGNATURE OF FUNERAL DIRECTOR, LICENSE NUMBER, NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME, PART I: IMMEDIATE CAUSE (Final disease or condition resulting in death), PART II: Other significant conditions, CERTIFIER (CERTIFYING PHYSICIAN, HEALTH OFFICER, CORONER), SIGNATURE AND TITLE OF CERTIFIER, MEDICAL LICENSE NO, DATE SIGNED, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH, HEALTH OFFICER'S SIGNATURE, DATE FILED, MANNER OF DEATH, DATE OF INJURY, TIME OF INJURY, INJURY AT WORK?, DESCRIBE HOW INJURY OCCURRED, PLACE OF INJURY, LOCATION, DATE PRONOUNCED DEAD, MOTOR VEHICLE ACCIDENT?, DATE FILED.



Hoffman's 2nd Add  
lot 33 Block C  
26-34-0107-0028

2007-01-31

11- LP  
CS