(10)

* 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.

Local No. 826-07

32982

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2007 JUN 26 PM 12:27
MICHAEL A. BROWN
RECORDER

State No. 2007-052028

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)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Denelda June Symmes		Female	2400 hrs.	March 23, 2007
4. * SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo., Day, Yr.)
507-22-0888	81			February 10, 1926
7. BIRTHPLACE (City and State or Foreign Country)				
Kearney, Nebraska				
8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	PLACE OF DEATH (Check only one)		
No	N/A	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA	OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence	
9b. FACILITY NAME (If not institution, give street and number)		9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH	
St. Anthony Medical Center		Crown Point	Lake	
10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY	
Widowed	N/A	Homemaker	Own Home	
13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER	
Indiana	Lake	Crown Point	11720 Burr St.	
13e. ZIP CODE	13f. INSIDE CITY LIMITS	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE — American Indian, Black, White, etc. (Specify)
46307-	[ ] No [X] Yes	USA	[X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	White
	13g. ON A FARM? [X] No [ ] Yes			

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)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Fred Craig	Goldie Hill

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Jill Allen	3523 186th St. Lansing, IL 60438-	Daughter

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment	March 28, 2007 Maplewood Memorial Cemetery	Crown Point, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Kevin Knaga	FD20400005	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Kevin Knaga	FD20400005	Geisen Funeral Home FH19900060 109 N. East St. Crown Point, Indiana 46307-

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.

X

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Renal Failure — Approximate Interval Between Onset and Death: Acute

DUE TO (OR AS A CONSEQUENCE OF):
b. Liver Failure — Acute

DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive Heart Failure — Acute

DUE TO (OR AS A CONSEQUENCE OF):
d. Intestinal Ileus — Acute

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: Cirrhosis liver old hepatitis Hip Replacement

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No

CERTIFIER

29a. CERTIFIER (Check only one)

[X] 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
x [signature]	x 25010	x 3/29/07

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. William J. Pierce M.D.
210 E. 90th Dr., Merrillville, IN 46410

31. HEALTH OFFICER'S SIGNATURE: Suzanne Burt D.O.

FILED
JUN 26 2007
PEGGY MOLINGA KATONA
LAKE COUNTY AUDITOR

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

32. DATE FILED (Month, Day, Year): March 29 2007

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				MAR 29 2007

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.

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