

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. 405-00

865786

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Fontello Gearhart</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>7:18 A.M.</b>	3b DATE OF DEATH (Month Day, Yr.) <b>February 13, 2000</b>	
4 *SOCIAL SECURITY NUMBER <b>310-22-3689</b>	5a AGE—Last Birthday (Years) <b>92</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr.) <b>Jul. 30, 1907</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Oscalusa, Iowa</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</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 checked="" 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>7726 Hohman Ave.</b>		9c CITY TOWN OR LOCATION OF DEATH <b>Munster</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Never Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Registered Nurse</b>		12b KIND OF BUSINESS/INDUSTRY <b>Chemical Manufacturing</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Munster</b>		13d STREET AND NUMBER <b>7726 Hohman Ave.</b>	
13e ZIP CODE <b>46321</b>	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? <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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>3</b>			
18 FATHER'S NAME (First Middle Last) <b>Forest Gearhart</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>Dollie Temple</b>			
20a INFORMANT'S NAME (Type/Print) <b>Lenora Janiga</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) <b>7726 Hohman Ave., Munster, Ind., 46321</b>		20c Relationship <b>Sister</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <b>February 17, 2000 Hillcrest Cemetery</b>		21c LOCATION—City or Town State <b>Moravia, Iowa</b>	
22a EMBALMER'S NAME <b>David R. Peterson</b>		22b EMBALMER'S LICENSE NO. <b>FDO 8601585</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>FDO 1014511</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home, 9039 Kleinman Rd Highland, Indiana 46322 FH 83007500</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. <b>Intermittent Heart Disease</b> a DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d				Approximate Interval Between Onset and Death	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Chronic congestive Heart Failure Chronic Atrial Fibrillation</b>				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 <b>James B. Waldrus</b>		29c MEDICAL LICENSE NO. <b>01027487</b>		29d DATE SIGNED (Month, Day, Year) <b>2/14/00</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>JAMES B. WALSH M.D., 5500 HOHMAN, HAMMOND, IN 46320</b>					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					
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>FILED</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) <b>JUL - 2 2007</b>			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or No. If yes, specify Other (Specify)) <b>LAKE COUNTY AUDITOR</b>		<b>008641</b>	