\

ATTENTION ESTATE: The Social Security # is [b]eing requested by this state agency in order to [p]ursue its statutory responsibility. Disclosure is [v]oluntary and there will be no penalty for refusal.

[L]ocal No. 4140-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

[T]YPE/PRINT IN [P]ERMANENT [B]LACK INK

[D]ECEDENT

- 1. DECEASED—NAME (First, Middle, Last): BETH ANN HERR
- 2. SEX: FEMALE
- 3a. TIME OF DEATH: 9:25 P M
- 3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 13, 2005
- 4. *SOCIAL SECURITY NUMBER: 308-68-4805
- 5a. AGE—Last Birthday (Years): 49
- 5b. UNDER 1 YEAR (Months / Days):
- 5c. UNDER 1 DAY (Hours / Minutes):
- 6. DATE OF BIRTH (Mo. Day, Yr): NOVEMBER 14, 1956
- 7. BIRTHPLACE (City and State or Foreign Country): CHICAGO HEIGHTS, ILLINOI
- 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: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
- 9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY MEDICAL CENTER
- 9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
- 9d. COUNTY OF DEATH: LAKE
- 10. MARITAL STATUS (Specify): MARRIED
- 11. SURVIVING SPOUSE (If wife, give maiden name): FRED HERR
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MACHINIST
- 12b. KIND OF BUSINESS/INDUSTRY: BEARING
- 13a. RESIDENCE—STATE: INDIANA
- 13b. COUNTY: LAKE
- 13c. CITY, TOWN, OR LOCATION: LOWELL
- 13d. STREET AND NUMBER: 7203 W. 211 TH.
- 13e. ZIP CODE: 46356
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 12; College (1-4 or 5 +):

[P]ARENTS

- 18. FATHER'S NAME (First, Middle, Last): AMEL WILKING
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): DORIS E. ROBERTS

[I]NFORMANT

- 20a. INFORMANT'S NAME (Type/Print): FRED HERR
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7203 W. 211th. LOWELL, INDIANA 46356
- 20c. Relationship: HUSBAND

[D]ISPOSITION

- 21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 17, 2005 CHAPEL LAWN MEMORIAL GARDENS
- 21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
- 22a. EMBALMER'S NAME: MARC MOSQUEDA
- 22b. EMBALMER'S LICENSE NO.: FD08800240
- 23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
- 24b. LICENSE NUMBER (of Licensee): FD01006015
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN MILLER FUNERAL HOME, FH10200006 8580 WICKER AVENUE ST. JOHN, INDIANA 46373

[C]AUSE OF [D]EATH

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)		Approximate Interval Between Onset and Death
a.	Cardiogenic Shock	3 days
b.	DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Heart Disease	2 wks
c.	DUE TO (OR AS A CONSEQUENCE OF): Cirrhosis of Liver	8 yrs
d.	DUE TO (OR AS A CONSEQUENCE OF):	

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): NO
- 28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
- 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

[C]ERTIFIER

29a. CERTIFIER (Check only one):
- ☐ 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: [signature]
- 29c. MEDICAL LICENSE NO.: 24382
- 29d. DATE SIGNED (Month, Day, Year): 12/16 2005
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 8895 Broadway Merrillville

[H]EALTH [O]FFICER

- 31. HEALTH OFFICER'S SIGNATURE: Susan D Bert D.O.
- 32. DATE FILED (Month, Day, Year): December 16, [2005]

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

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

DEC 1 6 2005

23952 CS

FILED DEC 05 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

2007 087796

Parcel #'s 3-30-3, 6, 7, 9, 11, 15; 3-33-1; 3-34-1 & 3

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