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. 15 26-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

INDIANA TITLE NETWORK
325 NORTH MAIN
CROWN POINT, IN 4630

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (First, Middle, Last): Patricia E. Blankenship
2. SEX: Female
3a. TIME OF DEATH: 06:35 AM
3b. DATE OF DEATH (Month, Day, Yr): May 31, 2005
4. *SOCIAL SECURITY NUMBER:
5a. AGE—Last Birthday (Years): 61
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): December 2, 1943
7. BIRTHPLACE (City and State or Foreign Country): Chicago IL
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 ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 3808 W. 231st
9c. CITY, TOWN, OR LOCATION OF DEATH: Lowell
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): George Blankenship
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Book Keeper
12b. KIND OF BUSINESS/INDUSTRY: Auto Parts Dealer
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lowell
13d. STREET AND NUMBER: 3808 W. 231st
13e. ZIP CODE: 46356
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Herbert Reif
19. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Erickson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): George Blankenship
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 W. 231st, Lowell, In 46356
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jun 2, 2005 Heritage Crematory
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ken Sheets
24b. LICENSE NUMBER (of Licensee): FD08900045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356

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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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Myocardial Infarct
DUE TO (OR AS A CONSEQUENCE OF)
b. Ovarian Carcinoma — Approximate Interval Between Onset and Death: 2 years
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
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

I AFFIRM, UNDER THE PENALTIES FOR PERJURY, THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW.

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):

CERTIFIER

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
29c. MEDICAL LICENSE NO.: 01041301
29d. DATE SIGNED (Month, Day, Year): 6/1/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Cheryl Morgan-Ihrig M.D. 1630 45th Ave., Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Blix
32. DATE FILED (Month, Day, Year): June 2, 2005

FILED

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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

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