

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

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

Nov. 19, 2007 Date Issued
P. R. ... Health Commissioner

Local No. 717

State No.

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

1 DECEASED—NAME (First, Middle, Last) SHARON ABLES		2 SEX FEMALE	3a. TIME OF DEATH 5:20P	3b. DATE OF DEATH (Month, Day, Yr.) NOVEMBER 11, 2007
4. *SOCIAL SECURITY NUMBER 303-54-3737	5a. AGE—Last Birthday (Years) 58	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) MARCH 6, 1949
7. BIRTHPLACE (City and State or Foreign Country) SANITARIUM, CALIFORNIA		8a. WAS DECEDENT A U.S. VETERAN? NO		
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		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) X Residence		
9b. FACILITY NAME (If not institution, give street and number) 4423 SHEFFIELD AVE		9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND	9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) JOHN ABLES	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b. KIND OF BUSINESS/INDUSTRY OWNHOME
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND	13d. STREET AND NUMBER 4423 SHEFFIELD AVE	
13e. ZIP CODE 46327	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 4 College (1-4 or 5+) 4		18. FATHER'S NAME (First, Middle, Last) Benjamin Greening		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Jewel Lynam		20a. INFORMANT'S NAME (Type/Print) JOHN ABLES		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 SHEFFIELD AVE HAMMOND, INDIANA 46327		20c. Relationship SPOUSE		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) NOVEMBER 19, 2007 HEIGHTS CREMATORY		21c. LOCATION—City or Town, State CHICAGO HEIGHTS, ILLINOIS
22a. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. NONE		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of licensee) FD29600125	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME POWELL COLEMAN FUNERAL HOME 190 WASHINGTON ST GARY INDIANA FH19900066	
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. Progressive Pulmonary Fibrosis		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		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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01031582	29d. DATE SIGNED (Month, Day, Year) 11-13-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) LYLE R. Munn 4391 First St E. Chicago IN 46312				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) November 19 2007
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 \$ 11		34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 23979		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				