

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 2354-07

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) James C. Ritenour		2. SEX Male	3a. TIME OF DEATH 4:06 am	3b. DATE OF DEATH (Month, Day, Yr.) September 30, 2007	
4. *SOCIAL SECURITY NUMBER 306-34-1032	5a. AGE - Last Birthday (Years) 72	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) March 03, 1935	
7. BIRTHPLACE (City and State or Foreign Country) Gary Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1963		PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Deborah Joyce Rush	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 Steel Manufacture		
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 3601 W. 49th Ave.		
13e. ZIP CODE 46342	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 (0-12) 12 College (1-4 or 5+) N/A		18. FATHER'S NAME (First, Middle, Last) James A. Ritenour			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Crider			20. INFORMANT'S NAME (Type/Print) Deborah Joyce Ritenour		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 W. 49th Ave., Hobart, IN 46342		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) October 4, 2007 Chapel Lawn Memorial Gardens		21c. LOCATION - City or Town, State Schererville, Indiana	
22a. EMBALMER'S NAME James E. Burns		22b. EMBALMER'S LICENSE NO. FD20700059	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): <i>Aspiration pneumonia</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Advanced dementia / Heart failure</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Agry</i> 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? (Y, N or U) 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. 01061624A	29d. DATE SIGNED (Month, Day, Year) 10-2-07		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jose Luis Agusti, MD 2640 Hamstrom Rd., Portage, IN 46368					
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Best, D.O.</i>			32. DATE FILED (Month, Day, Year) October 2, 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) FILED DEC 26 2007	34b. TIME OF INJURY (Yes or no)	34c. DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. OCT 02 2007 \$11 CWA	
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) At home		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3601 W. 49th Ave., Hobart, IN 46342			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) September 30, 2007		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) (If yes, specify driver, passenger, pedestrian, etc.) LAKE COUNTY AUDITOR 025534			

927-8371
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2-7-17-37-20

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DEC 28 AM 9:13
LAKE COUNTY HEALTH DEPARTMENT
FILED FOR RECORD

