

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. 055521

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

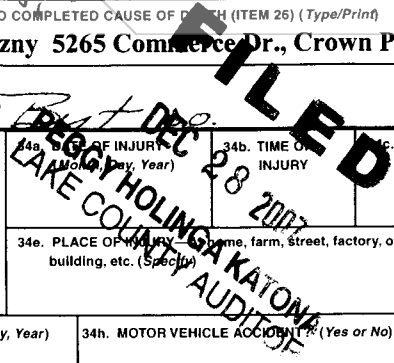
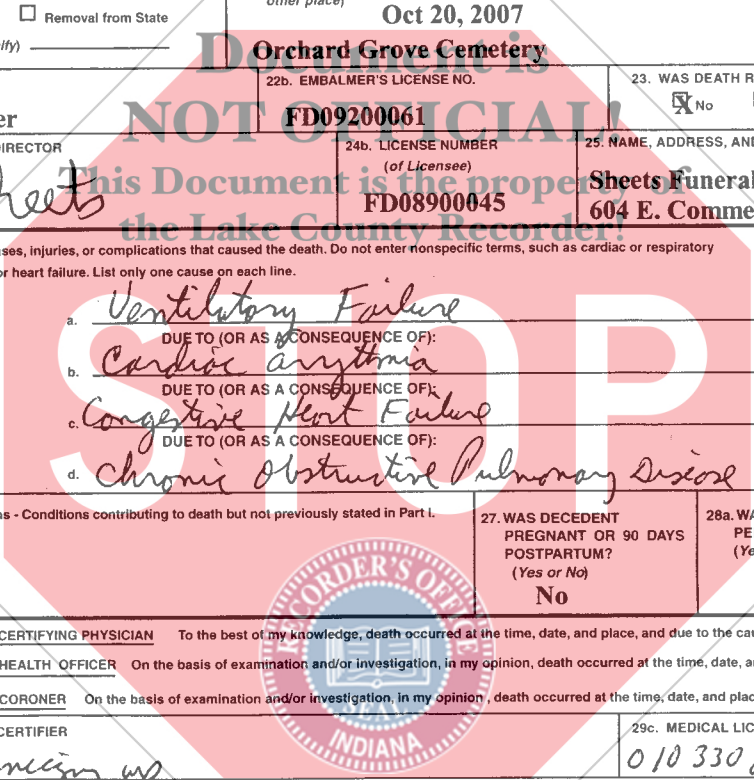
DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Delores L. Carlson				2. SEX Female	3a. TIME OF DEATH 07:10 PM	3b. DATE OF DEATH (Month, Day, Year) October 16, 2007	
4. *SOCIAL SECURITY NUMBER 314-30-1890		5a. AGE—Last Birthday (Years) 75	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) November 6, 1931		7. BIRTHPLACE (City and State or Foreign Country) South Dakota
8a. WAS DECEASENT 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: <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 type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Chicagoland Christian Village				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) Lee Carlson		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 Own Home	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Shelby		13d. STREET AND NUMBER 23309 Fillmore Box 141	
13e. ZIP CODE 46377		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEASENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) 1230			
18. FATHER'S NAME (First, Middle, Last) Adolf Ekern				19. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha B. Cochran			
20a. INFORMANT'S NAME (Type/Print) Lee W. Carlson				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 23309 Fillmore Box 141, Shelby, In 46377		20c. Relationship Husband	
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) Oct 20, 2007 Orchard Grove Cemetery			21c. LOCATION—City or Town, State Lowell	
22a. EMBALMER'S NAME: Molly E. Tucker			22b. EMBALMER'S LICENSE NO. FD09200061		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ken Sheets</i>			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		
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. <i>Ventilatory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Chronic Obstructive Pulmonary Disease</i> Approximate Interval Between Onset and Death <i>20 minutes</i> <i>20 minutes</i> <i>6 months</i> <i>1 year</i>							
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.				27. WAS DECEASENT 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)							
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>Elizabeth Przeniczny MD</i>					29c. MEDICAL LICENSE NO. 010 33089		29d. DATE SIGNED (Month, Day, Year) 10-27-2007
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Elizabeth Przeniczny 5265 Commerce Dr., Crown Point, IN 46307							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best</i>							32. DATE FILED (Month, Day, Year) October 31, 2007
33. MANNER OF DEATH <input checked="" 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) DEC 28 2007		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or No)	
		34d. DESCRIBE HOW INJURY OCCURRED		34e. PLACE OF INJURY (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. 24927			



STATE OF INDIANA
LAKE COUNTY RECORDER'S OFFICE
FILED
NOV 12 11:02 AM '07
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add
5351
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