\* 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. 99–0785

## INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

BLACK INK  491-16-0389  Mary Strong S		THE RECORDS IN THIS	SERIES ARE CONFIDENTIAL PE	ER IC 16-1-19-3			O.C.	200 140.		· • • • • • • • • • • • • • • • • • • •	
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SPOSITION  226 EMBALMETS NAME  226 EMBALMETS ALMES  ROSENWALD D. Allen Jr. 226 EMBALMES CLEASE NUMBER  229 APRIVATURE OF FUNERAL DIRECTOR  230 APART II Content the desales notifies or complements that cause this death of the content of the con		<b>—</b>	1 -	other place) N(	o <del>r dispositi</del> o Ovembe 1	ON (Name of sem	etery crematory or 999	21c LOCAT		State	
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DUE TO LOR AS A CONSEQUENCE OF PEGGY HOLINGA KATONA  PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.  27 WAS DECEDENT PRECIABLY OF 90 DAYS POSTPARTUM? PRECIABLY OF 90 DAYS PRECIAB	Con	nditions if any which gave	bDUE TO (OR A	S A CONSEQUENCE O	E)		CED OF A				
PART II Other significant conditions contributing to death but not previously stated in Part 1  27 WAS DECEDENT PRECNANT OR 90 DAYS PRECNANT OR 90 DAYS PERFORMED  28 WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Ves or no)  29a CERTIFIER (Check only)   HEALTH OFFICER On the bass of examination and/or investigation in my pomping death occurred at the time date and due to the cause(s) as stated   CORONER On the bass of examination and/or investigation in my pomping death occurred at the time date and due to the cause(s) as stated   CORONER On the bass of examination and/or investigation in my pomping death occurred at the time date and due to the cause(s) as stated   CORONER On the bass of examination and/or investigation in my pomping death occurred at the time date and due to the cause(s) as stated   29b MONATURE AND TITLE OF CERTIFIER   29c MEDICAL LICENSE NO   29d DATE SIGNED (Month Day 1/2-13-99   12-13-99   13 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type-Pimol)   Dr. David E. ROSS   MD 1619 West 5th Avenue Gary, Indiana 46404   13 HEALTH OFFICERS SIGNATURE   13 MANNER OF DEATH   34a DATE OF INJURY   34b TIME OF INJURY   14 NORWO   34d DESCRIBE HOW INJURY OCCURRED   15 NORMO   15 N	Statu	ng the underlying	c				1.00		*.		
PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I  27 WAS DECEDENT PRECINANT OR 90 DAYS PERFORMED? (Ves or no)  298 CERTIFIER (Check only one)  HEALTH OFFICER On the basis of examination and/or investigation from coursed at the time date and pace and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from coursed at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from coursed at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from coursed at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from coursed at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from coursed at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from dating occurred at the time date and place and due to the cause(s) as stated  CORONER On the basis of examination and/or investigation from datin	Caus	ie last		S A CONSEQUENCE O	F)	PEGG	Y HOLINGA H	ATON			
PRECNANT OR 90 DAYS  PRECNANT OR 90 DAYS  PRECNANT OR 90 DAYS  POSTPARTUM?  (Yes or no)  29a CERTIFIER  (Check only one)    MEALTH OFFICER On the basis of examination and/or investigation in my dominor death occurred at the time date and due to the cause(s) as stated    CORONER On the basis of examination and/or investigation in my dominor 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 dominor 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 dominor death occurred at the time date and place and due to the cause(s) and menner as stated    29b   ICNATURE AND JITLE OF CERTIFIER   29c   MEDICAL LICENSE NO   29d DATE SIGNED (Month Day 12 - 13 - 99)    10   10   10   10   10   10   10   1	PART	Till Other significant conditions - (	Conditions contributing to death but no	If Drawously states in On-			VOUNTY AT	DITO	A	·	
296 CERTIFIER  Check only Original Description of Cause of Death? (Yes or no)  1296 CERTIFIER  Check only Original Description of Cause of Death? (Yes or no)  1296 CERTIFIER  Check only Original Description of Cause of Death? (Yes or no)  1296 Condoner On the basis of examination and/or investigation in my domain death accurred at the time date and due to the cause(s) as stated or	7,			n previously stated in Par		PREGNANT OR	TOO TING AIL	AUTOPSY ED?			
299 CERTIFIER    Check only		Į.		STILL RD		Yes or no)			COMPLETION	N OF CAUSE	
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JANGE - Lan May  30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)  Dr. David E. Ross In MD 1619 West 5th Avenue Gary, Indiana 46404  31 HEALTH OFFICERS SIGNATURE  32 DATE FILED (Month Day Year)  33 MANNER OF DEATH  340 DATE OF INJURY  (Month Day Year)  340 DESCRIBE HOW INJURY OCCURRED  (Year or no)  341 LOCATION (Street and Number or Rural Route Number City or Town State)  352 DATE FILED (Month Day Year)  364 PLACE OF INJURY—At nome 'arm street (actory office)  365 Determined  366 Determined  367 PLACE OF INJURY—At nome 'arm street (actory office)  368 MEDICAL LICENSE NO  #01018989  12 - 13 - 999  374 DESCRIBE HOW INJURY OCCURRED  (Year or no)  375 DATE FILED (Month Day Year)  175 DATE FILED (Month Day Year)  187 DATE FILED (Month Day Year)  188 DATE SIGNATURE  375 DATE FILED (Month Day Year)  189 DATE SIGNATURE  376 DATE SIGNATURE  377 DATE SIGNATURE  378 DATE FILED (Month Day Year)  187 DATE FILED (Month Day Year)  187 DATE FILED (Month Day Year)  188 DATE SIGNATURE  378 DATE FILED (Month Day Year)  189 DATE SIGNATURE  379 DATE SIGNATURE  370 DATE SIGNATURE  371 DATE SIGNATURE  372 DATE SIGNATURE  373 DATE SIGNATURE  374 DATE SIGNATURE  375 DATE SIGNATURE  375 DATE SIGNATURE  375 DATE SIGNATURE  375 DATE SIGNATURE  376 DATE SIGNATURE  377 DATE SIGNATURE  377 DATE SIGNATURE  377 DATE SIGNATURE  378	<del></del>	7	Of the basis of examination ar	nd/or investigation in my	opinion death (	occurred at the tin	ne date and place and que to	o the cause(s)	:ause(s) as stated and manner as state(	1	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)  Dr. David E. Ross MD 1619 West 5th Avenue Gary, Indiana 46404  31 HEALTH OFFICERS SIGNATURE  32 DATE FILED (Month Day Year)  33 MANNER OF DEATH  34 DATE OF INJURY  (Month Day Year)  34 TIME OF SET INJURY AT NORKY  (Yes or no)  34 DESCRIBE HOW INJURY OCCURRED  (Yes or no)  34 PLACE OF INJURY—At home farm street factory office  34 LOCATION (Street and Number or Rural Route Number City or Town State)  3520	IFIER	James S.	D- W	(11,1N)	DIANA		29¢ MEDICAL LICENSE NO	1			
THER  31 HEALTH OFFICERS SIGNATURE  32 DATE FILED (Month Day Year)  33 MANNER OF DEATH  340 DATE OF INJURY (Month Day Year)  340 DATE OF INJURY (Month Day Year)  340 TIME OF INJURY (Yes or no)  341 LOCATION (Street and Number or Rural Route Number City or Town State)  3520  36 DATE FILED (Month Day Year)  37 DATE FILED (Month Day Year)  38 DATE OF INJURY (Yes or no)	30 NA	AME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	ATH (ITEM 26) (Type /P)	(at)		/		<u> 12-13-</u>	.49	
31 HEALTH OFFICERS SIGNATURE  32 DATE FILED (Month Day Year)  33 MANNER OF DEATH  348 DATE OF INJURY  (Month Day Year)  346 TIME OF JAC INJURY AT WORK?  (Yes or no)  340 DESCRIBE HOW INJURY OCCURRED  (Yes or no)  341 LOCATION (Street and Number or Rural Route Number City or Town State)  3520	-	Dr. David E. k	loss In MD 1619	9 West 5th	Avenu	e Gary,	Indiana 46	404			
346 DATE OF INJURY    Natural   Pending Investigation   Accident   Suicide   Could not be Determined   Determined   Determined   Determined   Suicide   Could not be Determined   Determined   Suicide   Could not be Determined   Suicide   Could not	'H   31 H€.	ALTH OFFICERS SIGNATURE	V200	A 1	<u> </u>				32 DATE FILED (Mo	onth Day Year)	
(Month Day Year)    Natural   Pending   Investigation   Accident   Suicide   Could not be Determined   Determined   Determined   Determined   Determined   Suicide   Could not be Determined   Suicide   Determined   Suicide   Determined   Suicide   Determined   Suicide   Specify   Suicide   Suicide   Specify   Suicide   Suicid	33 MA	INNER OF DEATH	340 DATE OF IN HIDY			7P			. DEC 13	1999	
Accident   Accident   Suicide   Could not be Determined   Suicide   Determined   Suicide   Suicide   Could not be Determined   Suicide				1	Yes or n	A <b>T ₩0#K</b> ? ø)	34d DESCRIBE HOW IN	NURY OCCL	JARED	. 190	
Suicide Could not be Determined  34 PLACE OF INJURY — At home farm street factory office building etc (Specify)  34 LOCATION (Street and Number or Aural Route Number City or Town State)  3520	1	investigation							(	176	
3520		Suicide 🔲 Could not be	34+ PLACE OF INJURY — At building etc (Specify)	home farm street factor	y office	341 LOC	ATION (Street and Number	or Rural Route	Number City or Tov	vn State)	
34g DATE PRONOUNCED DEAD (Month Day Year) 34h MOTOR VEHICLE ACCIDENT? (Yes or not if yes specify driver passenger bedestrian etc.		Determined Homicide						352	20		
	34g DA	TE PRONOUNCED DEAD (Month	Day Year) 34h MOTOR VEHIC	LE ACCIDENT? (Yes o	rnoz if yes sp	pecify driver pass	tenger pedestrian air			· · · · · · · · · · · · · · · · · · ·	
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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1	SDH06	5-004 State Form 101	10 (R4/3-93) Deathcer/F	PD 1							