INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Keyit (20) 13-577-3

Local No. 636-08 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
BETTY DELL SMITH	STORM	F	6:30 PM	FEBRUARY 19, 2008

5. Social Security Number	6a. Age Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
351-16-4335	82	Months	Days	Hours	Minutes	August 16, 1925	WHEELING, IL

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): 205 BARBARA JEAN DR.

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
SCHERERVILLE, IN 46375	LAKE	☒ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
JOHN SMITH	NA	HOMEMAKER	OWN HOME

18. Residence – State	18a. County	18b. City Or Town
INDIANA	LAKE	SCHERERVILLE

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
205 BARBARA JEAN DR.	NA	46375	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
High school graduate or GED completed	No, not Spanish/Hispanic/Latino	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
PAUL STORM	MABEL STORM	LEMM

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
JOHN SMITH	HUSBAND	205 BARBARA JEAN DR., SCHERERVILLE, IN 46375

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, INDIANA

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	CHAPEL LAWN FUNERAL HOME 8178 S. CLINE AVE., SCHERERVILLE, INDIANA 46375	FH19900051

27b. Signature Of Indiana Funeral Service Licensee	27c. License Number (Of Licensee)
Tara L. Wright	20400058

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

			Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A	Non-Small Cell Lung Cancer (Due To (Or As A Consequence Of))	2 months
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last	B	(Due To (Or As A Consequence Of))	
	C	(Due To (Or As A Consequence Of))	
	D		

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death
☐ Yes ☒ Probably ☐ No ☐ Unknown	☒ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
NA	NA	NA	☐ Yes ☒ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code
NA	NA	NA	NA	NA

39. Describe How Injury Occurred: NA

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
CHERYL MORGAN-IHRig, M.D. 1630-45th St. Munster IN	104301	2-21-08

46. Additional Funeral Service Provider:	47. *Akas:
NA	NA

48. Signature of Local Health Officer:	49. For Registrar Only – Date Filed (Month/Day/Year):
Susan W Burt D.O.	February 22, 2008

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10

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