

\* ATTENTION ESTATE: The Social Security # is being reported by this state agency in order to pursue its statutory responsibility. Disclosure of will, name and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

158720

Local No. 135

CERTIFICATE OF DEATH

State No. City of East Chicago East Chicago, IN 46312

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

1067-0025

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Loretta L. Hill</b>		2 SEX <b>Female</b>		3a TIME OF DEATH <b>10:12A.M</b>		3b DATE OF DEATH (Month Day, Yr) <b>June 7, 2007</b>	
4 *SOCIAL SECURITY NUMBER <b>417-72-8608</b>		5a AGE—Last Birthday (Years) <b>59</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day, Yr) <b>June 22, 1947</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Allen, Alabama</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <b>Regency Hospital</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>East Chicago</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Never Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Personal Banker</b>		12b KIND OF BUSINESS/INDUSTRY <b>Standard Bank</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>East Chicago</b>		13d STREET AND NUMBER <b>4333 Homerlee</b>	
13e ZIP CODE <b>46312</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>Black</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4yrs</b> College (1-4 or 5+) <b>4yrs</b>					
18 FATHER'S NAME (First Middle Last) <b>Robert Lynum</b>				19 MOTHER'S NAME (First Middle Maiden Surname) <b>Arlean Hill</b>			
20a INFORMANT'S NAME (Type/Print) <b>Mary L. Hill</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4446 Olcott #D2 East Chicago, IN 46312</b>		20c Relationship <b>Sister</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) <b>June 16, 2007 St. Peter's Cemetery</b>		21c LOCATION—City or Town, State <b>Allen, Alabama</b>			
22a EMBALMER'S NAME <b>Tracy Cheri Williams</b>		22b EMBALMER'S LICENSE NO. <b>FD08600238</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <b>0</b>			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b LICENSE NUMBER (of Licensee) <b>FD08600238</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Hinton &amp; Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, IN 46312 FH83001520</b>			
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>Coronary atherosclerosis</i> b <i>Myocardial infarction</i> c d Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		Approximate Interval Between Onset and Death	
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>Dr. Young Kim</i>				29c MEDICAL LICENSE NO. <b>01027851</b>		29d DATE SIGNED (Month Day Year) <b>6/8/07</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Young Kim 4035 Elm Street East Chicago, Indiana 46312</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Paula Bonheur Robinson MD</i>						32 DATE FILED (Month Day Year) <b>6/11/07</b>	
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)	
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) <b>04845</b>		34d DESCRIBE HOW INJURY OCCURRED <b>FILED MAR 09 2008</b>					
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, or pedestrian. <b>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR</b>					

SDH06-004 State Form 10110 (R5/1 00)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT