

ATTENTION ESTATE: The Social Security # is requested by this state agency in order to sue its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 810-05 State No. \_\_\_\_\_

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

PE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

IDENTS

FORMANT

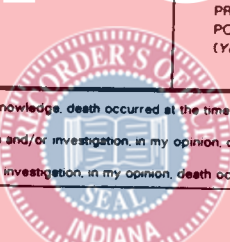
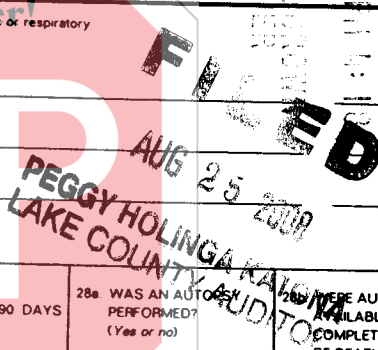
POSITION

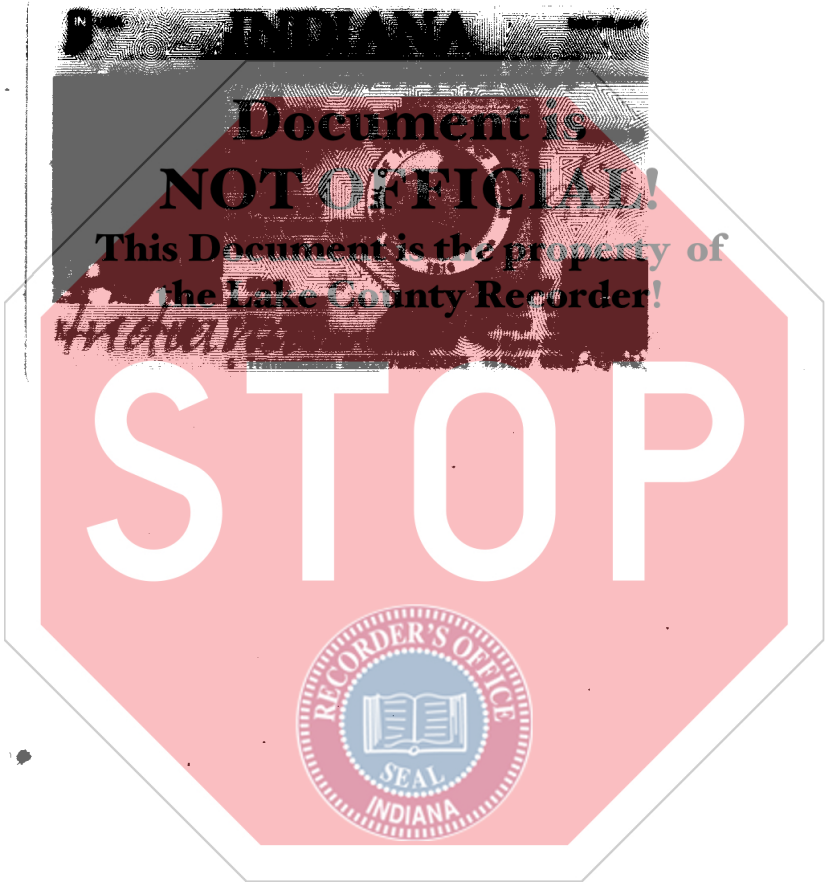
USE OF  
THIS

CERTIFIER

HEALTH  
OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>Sarah Anne Boruff</b>				2 SEX <b>Female</b>		3a TIME OF DEATH <b>8:00PM</b>		3b DATE OF DEATH (Month, Day, Yr) <b>March 19, 2005</b>	
4 *SOCIAL SECURITY NUMBER <b>314-24-1595</b>		5a AGE—Last Birthday (Years) <b>90</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) <b>October 8, 1914</b>	
8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES?		9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) <b>229 N. Ohio ST.</b>				9c CITY, TOWN, OR LOCATION OF DEATH <b>Hobart, In</b>			9d COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Richard M. Boruff</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>School Teacher</b>			12b. KIND OF BUSINESS/INDUSTRY <b>Education</b>		
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>Hobart</b>			13d. STREET AND NUMBER <b>229 N. Ohio St.</b>		
13e. ZIP CODE <b>46342</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</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>White</b>	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		18. FATHER'S NAME (First, Middle, Last) <b>Joseph Mundell</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Gearhardt</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Richard M. Boruff</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>229 N. Ohio St. Hobart, IN. 46342</b>				20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>March 22, 2005 Kraft Funeral Services and Crematory, Inc.</b>			21c. LOCATION—City or Town, State <b>HOBART, INDIANA</b>		
22a. EMBALMER'S NAME <b>n/a</b>				22b. EMBALMER'S LICENSE NO. <b>n/a</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Donald E. Kraft Jr.</i>				24b. LICENSE NUMBER (of Licensee) <b>FD29300105</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kraft Funeral Services and Crematory, Inc. FH10000005 370 N County Line Rd. Hobart, IN 46342</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. <b>Emphysema</b> DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) 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>			
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. <b>01039453</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/21/05</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>John Carter 295 S. Wisconsin St. HOBART, INDIANA. 46342</b>									
31. HEALTH OFFICER'S SIGNATURE <i>Susan W But...</i>						32. DATE FILED (Month, Day, Year) <b>March 23, 2005</b>			
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)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		
34a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)			34d. 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. <b>AUG 25 2008</b>			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>011826</b>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					





INDIANA

Document #

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