6200 84149

* **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. 166

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT

March 8, 2006 — Date Issued

[signature] MD — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Trinidad Hernandez
2. SEX	Male
3a. TIME OF DEATH	4:00 A M
3b. DATE OF DEATH (Month, Day, Yr.)	March 5, 2006
4. *SOCIAL SECURITY NUMBER	[redacted]
5a. AGE—Last Birthday (Years)	80
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Sept. 9, 1925
7. BIRTHPLACE (City and State or Foreign Country)	Brownsville, TX
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1946
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify)	☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	1150 Hoffman Ave.
9c. CITY, TOWN, OR LOCATION OF DEATH	Hammond
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Ernestina Aguilar
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Steelworker
12b. KIND OF BUSINESS/INDUSTRY	Steel
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	1150 Hoffman Ave.
13e. ZIP CODE	46320
13f. INSIDE CITY LIMITS ☐ No ☒ Yes	Yes
13g. ON A FARM? ☒ No ☐ Yes	No
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	Mexican
16. RACE—American Indian, Black, White, etc. (Specify)	Hispanic
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5 +)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Jose Trinidad Hernandez
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Petra Castillo

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Ernestina Hernandez
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1150 Hoffman Ave., Hammond, IN 46320
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Burial
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March 9, 2006 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State	Schererville, IN
22a. EMBALMER'S NAME	Steven J. Struck
22b. EMBALMER'S LICENSE NO.	FDO 8600181
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	No
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FDO 8600181
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Chapel Lawn Memorial Gardens/Funeral H 8178 Cline Avenue Schererville, Indiana 46375 FH19900051

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. complications of Alzheimers

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.

Field	Entry
27. WAS DECEDENT 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)	NA

CERTIFIER

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

☐ 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.

☐ 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature] DO
29c. MEDICAL LICENSE NO.	02002596A
29d. DATE SIGNED (Month, Day, Year)	3/6/2006 (March)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	SAMEEA CHUGHTAI 7905 CALUMET AVE MUNSTER, IN 46321

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] MD
32. DATE FILED (Month, Day, Year)	March 8, 2006

Field	Entry
33. MANNER OF DEATH ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide	
34a. DATE OF INJURY (Month, Day, Year)	
34b. TIME OF INJURY	
34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY—At 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.	

$11 CT

J13825

FILED SEP 16 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

SDH06-004 State Form 10110 (R5/1-99)