

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1330-06

CERTIFICATE OF DEATH

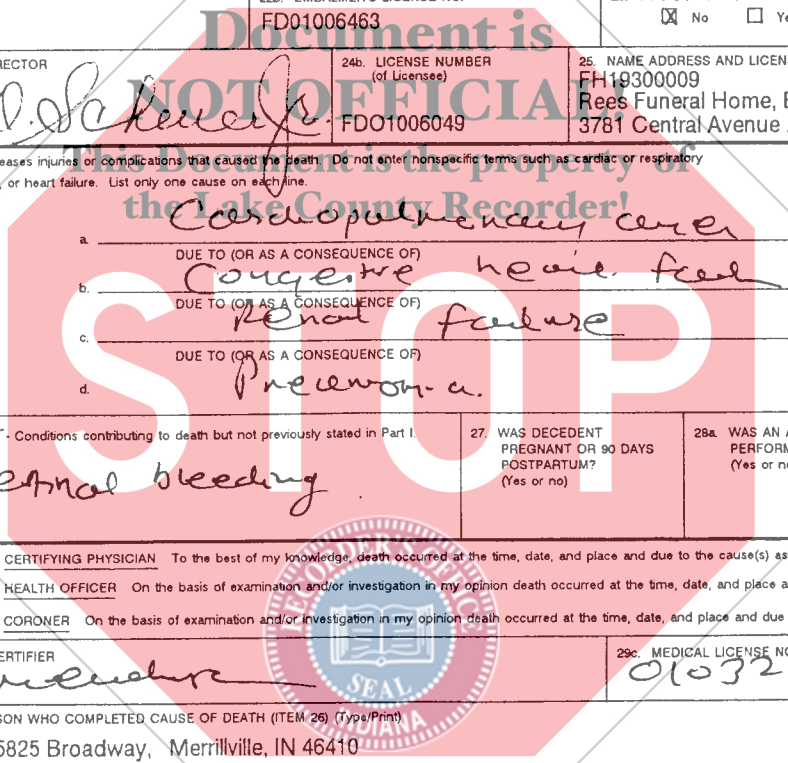
State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED-NAME (First Middle Last) BRUCE EUGENE BAIRD				2. SEX Male		6a. TIME OF DEATH 9:44PM		6b. DATE OF DEATH (Month Day Yr) May 27, 2006							
4. SOCIAL SECURITY NUMBER 314-30-1814		5a. AGE - Last Birthday (Years) 73		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo Day Yr) July 5, 2002 NOV 17, 1928		7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana					
8a. WAS DECEASENT U.S. ARMY AIR FORCE Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1961		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 checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence				9b. FACILITY NAME (If not institution, give street and number) St. Mary's Medical Center				9c. CITY TOWN OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Shirley Ennis		12a. DECEASENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) General Contractor				12b. KIND OF BUSINESS INDUSTRY General							
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY TOWN OR LOCATION Lake Station				13d. STREET AND NUMBER 2430 Marquette Road							
13e. ZIP CODE 46405		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEASENT 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) White		17. DECEASENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12					
18. FATHER'S NAME (First, Middle, Last) William Baird						19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Broschart									
20a. INFORMANT'S NAME (Type/Print) Shirley Baird				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2430 Marquette Rd., Lake Station, IN 46405				20c. Relationship Wife							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) June 1, 2006 Chapel Lawn Memorial Gardens				21c. LOCATION - City or Town State Scherverville, Indiana							
22a. EMBALMER'S NAME James J. Krause				22b. EMBALMER'S LICENSE NO. FD01006463				23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scherverville</i>				24b. LICENSE NUMBER (of licensee) FDO1006049		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH19300009 Rees Funeral Home, Brady Chapel 3781 Central Avenue, Lake Station, IN 46405									
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. <u>Cardiopulmonary arrest</u> b. <u>Congestive heart failure</u> c. <u>Renal failure</u> d. <u>Pneumonia</u> Conditions if any which gave rise to the immediate cause stating the underlying cause last										Approximate Interval Between Onset and Death					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <u>gastrointestinal bleeding</u>						27. WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)					
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>Surenra Shah MD</i>				29c. MEDICAL LICENSE NO. 01032180		29d. DATE SIGNED (Month Day Year) 6/1/06							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Surenra Shah MD, 5825 Broadway, Merrillville, IN 46410										31. HEALTH OFFICER'S SIGNATURE <i>Surenra Shah MD</i>		32. DATE FILED (Month Day Year) June 1, 2006			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day Yr) FILED NOV 17 2008		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED LAKE COUNTY HEALTH DEPARTMENT							
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) NOV 17 2008				34f. LOCATION (Street and Number or Rural Route Number, City or Town State) 017824											
34g. DATE PRONOUNCED DEAD (Month, Day, Year) LAKE COUNTY AUDITOR										34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. 11/17/06					

COPY



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CAUSE OF DEATH