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. 2637-04

INDIANA STATE DEPARTMENT OF HEALTH

COPY

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): LAURA LYNN UBRIACO

2 SEX: FEMALE

3a TIME OF DEATH: 3:15 P.M

3b DATE OF DEATH (Month, Day, Yr): OCTOBER 30, 2004

4 *SOCIAL SECURITY NUMBER: 346-66-9248

5a AGE—Last Birthday (Years): 39

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Minutes):

6 DATE OF BIRTH (Mo, Day, Yr): DECEMBER 16, 1964

7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA

8a WAS DECEDENT A U.S. VETERAN?: NO

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL

9c CITY, TOWN, OR LOCATION OF DEATH: MUNSTER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): MARRIED

11 SURVIVING SPOUSE (If wife, give maiden name): KEN UBRIACO

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SECRETARY

12b KIND OF BUSINESS/INDUSTRY: INSURANCE

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN, OR LOCATION: ST. JOHN

13d STREET AND NUMBER: 8731 VERBENA COURT

13e ZIP CODE: 46373

13f INSIDE CITY LIMITS: ☐ No ☒ Yes

13g ON A FARM?: ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: USA

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

16 RACE—American Indian, Black, White, etc. (Specify): WHITE

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 2

PARENTS

18 FATHER'S NAME (First, Middle, Last): ROBERT MECHA

19 MOTHER'S NAME (First, Middle, Maiden Surname): PATRICIA REYNOLDS

INFORMANT

20a INFORMANT'S NAME (Type/Print): KEN UBRIACO

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8731 VERBENA COURT, ST. JOHN, IN 46373

20c Relationship: HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): NOVEMBER 6, 2004 CHAPEL LAWN MEMORIAL GARDENS

21c LOCATION (City or Town, State): SCHERERVILLE, INDIANA

22a EMBALMER'S NAME: SCOTT PREWITT

22b EMBALMER'S LICENSE NO.: FD01006861

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FD20400030

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN MILLER FUNERAL HOME, FH10200006 8580 WICKER AVENUE ST. JOHN, INDIANA 46373

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. anoxic episode

DUE TO (OR AS A CONSEQUENCE OF):

b. multiple sclerosis

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): 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): NO

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

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c MEDICAL LICENSE NO.: 01031674A

29d DATE SIGNED (Month, Day, Year): NOVEMBER 1, 2004

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DANIEL J. SMITH, M.D. 761 45TH STREET MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] D.O.

32 DATE FILED (Month, Day, Year): November 2, 2004

FILED APR 21 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

2009 025387

2009 APR 21 ... MICHAEL A. BROWN RECORDER ... FILED FOR RECORD ... LAKE COUNTY ... STATE OF INDIANA

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

34a DATE OF INJURY (Month, Day, Year):

34b TIME OF INJURY:

34c INJURY AT WORK? (Yes or no):

34d DESCRIBE HOW INJURY OCCURRED:

THIS CERTIFIES THE ABOVE TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY ...

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.

9027 11 00 #1572 PB

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