

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



Local No. 3826-08

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>MARY E. REED</b>				1a. Maiden Last Name (If Female) <b>Miller</b>		2. Sex <b>Female</b>	3. Time Of Death <b>6:10 am</b>	4. Date Of Death (Month/Day/Year) <b>November 5, 2008</b>		
5. Social Security Number [REDACTED]		6a. Age - Yrs <b>97</b>		6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year) <b>May 8, 1911</b>		
8. Birthplace (City And State Or Foreign Country) <b>Rockville IN</b>		9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input checked="" type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)						
11. Facility Name (If Not Institution, Give Street And Number) <b>Miller's Merry Manor</b>										
12. City Or Town, State, And Zip Code <b>Hobart, IN 46342</b>				13. County Of Death <b>Lake</b>			14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name <b>N/A</b>			15a. (If Wife) Give Maiden Last Name <b>N/A</b>			16. Decedent's Usual Occupation <b>Homemaker</b>		17. Kind Of Business/Industry <b>Home</b>		
18. Residence - State <b>IN</b>		18a. County <b>Lake</b>		18b. City Or Town <b>Hobart</b>				18d. Apt. No.	18e. Zip Code <b>46342</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18c. Street And Number <b>809 Cardinal Ct.</b>			19. Decedent's Education <b>8</b>							
20. Decedent Of Hispanic Origin <b>No not Spanish/Hispanic/Latino</b>			21. Decedent's Race <b>White</b>							
22. Father's Name (First, Middle, Last) <b>William C. Miller</b>				23. Mother's Name (First, Middle, Last) <b>Anna Miller</b>			23a. Mother's Maiden Last Name <b>Holbert</b>			
24. Informant's Name <b>Dennis Reed</b>		24a. Relationship To Decedent <b>Son</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>2310 W. 3rd St., Hobart, IN 46342</b>						
25a. Method Of Disposition: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>Graceland Cemetery</b>			25c. Location - City, Town, And State <b>Valparaiso, IN 46383</b>					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>Rees Funeral Home, 600 West Old Ridge Rd. P.O. Box 488, Hobart, Indiana 46342</b>					27a. Funeral Home License Number: <b>FH83003069</b>			
27b. Signature Of Indiana Funeral Service Licensee: <i>James J. Krause</i>					27c. License Number (Of Licensee): <b>FD01006463</b>					
28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death, Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. <b>congestive heart failure</b> <b>agrip</b>										
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I.										
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined					
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)				37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
38. Location Of Injury - State		38a. City Or Town <b>Hobart</b>		38b. Street & Number		38c. Apt. No.	38d. Zip Code <b>46342</b>			
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: <i>Jose Agusti MD</i>					42. Certifier (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer					
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>Jose Agusti MD, 2640 Hamstrom Road Portage, IN 46368</b>				44. License Number <b>01061624A</b>		45. Date Certified <b>11/02/08</b>				
46. Additional Funeral Service Provider:					47. *Akas: <b>002936</b>					
48. Signature of Local Health Officer: <i>Susan J. But. SO.</i>					49. For Registrar Only - Date Filed (Month/Day/Year): <b>November 12, 2008</b>					

Document is the property of the Lake County Recorder  
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MICHAEL A. GOWAN  
RECORDER  
2008 APR 22 AM 10:33  
STATE OF INDIANA  
CLERK OF SUPERIOR COURT  
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APR 20 2009  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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