



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

45-11-12-326-002.000-036

Local No. 2426-08

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>FELIX AYALA</b>		1a. Maiden Last Name (If Female) <b>N/A</b>		2. Sex <b>M</b>	3. Time Of Death <b>4:47 PM</b>	4. Date Of Death (Month/Day/Year) <b>JUNE 29, 2008</b>	
5. Social Security Number <b>580-76-4933</b>	6a. Age Yrs <b>65</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>May 17, 1943</b>	
8. Birthplace (City And State Or Foreign Country) <b>PUERTO RICO</b>		9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>					
10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" 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 type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street And Number) <b>METHODIST HOSPITAL SOUTHLAKE</b>							
12. City Or Town, State, And Zip Code <b>MERRILLVILLE, INDIANA 46410</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>NA</b>		15a. (If Wife) Give Maiden Last Name <b>NA</b>		16. Decedent's Usual Occupation <b>BUS DRIVER</b>		17. Kind Of Business/Industry <b>TRANSIT</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>SCHERERVILLE</b>			
18c. Street And Number <b>6515 COYOTE LANE</b>				18d. Apt. No. <b>NA</b>	18e. Zip Code <b>46375</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education <b>8th grade or less</b>		20. Decedent Of Hispanic Origin <b>Yes, Puerto Rican</b>		21. Decedent's Race <b>Other (Specify): Puerto Rican white</b>			
22. Father's Name (First, Middle, Last) <b>ALBERTO AYALA</b>			23. Mother's Name (First, Middle, Last) <b>LEONOR AYALA</b>			23a. Mother's Maiden Last Name <b>FLOREZ</b>	
24. Informant's Name <b>DANIEL MONTALVO</b>		24a. Relationship To Decedent <b>COUSIN</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>2551 CAMELOT DR. DYER, INDIANA 46311</b>			
25a. Method Of Disposition: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input 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>CHAPEL LAWN MEMORIAL GARDENS</b>		25c. Location - City, Town, And State <b>SCHERERVILLE, INDIANA</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>CHAPEL LAWN FUNERAL HOME, 8178 S. CLINE AVE., SCHERERVILLE, INDIANA 46375</b>				27a. Funeral Home License Number: <b>FH19900051</b>	
27b. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>				27c. License Number (Of Licensee) <b>FD08600181</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. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <b>Primary Ventricular Fibrillation</b> <span style="float: right;">Approximate Interval: Onset To Death <b>less than 1 hr</b></span> B. <b>Coronary artery disease</b> C. _____ D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last							
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. <b>Diabetes</b>				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 type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within 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, But 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) <b>NA</b>		35. Time Of Injury <b>NA</b>		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) <b>NA</b>		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
38. Location Of Injury - State <b>NA</b>		38a. City Or Town <b>NA</b>		38b. Street & Number <b>NA</b>		38c. Apt. No. <b>NA</b>	
38d. Zip Code <b>NA</b>		39. Describe How Injury Occurred <b>NA</b>					
40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) <b>CS</b>							
41. Signature, Of Person Certifying Cause Of Death: <i>[Signature]</i> <b>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR</b>				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>Angel Castaner 71 W. 156th St, Suite 305 Harvey IL 60426</b>				44. License Number <b>036-4351282</b>		45. Date Certified <b>7-1-2008</b>	
46. Additional Funeral Service Provider: <b>NA</b>				47. *Akas: <b>NA</b>			
48. Signature of Local Health Officer: <i>[Signature]</i>				49. For Registrar Only - Date Filed (Month/Day/Year): <b>July 1, 2008</b>			