ATTENTION ESTATE: The Social Security # is ng requested by this state agency in order to sue its statutory responsibility. Disclosure is untary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

ical No. 14654 State No. 620085939

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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| 1. DECEASED—NAME (First, Middle, Last): SHIRLEY V. NELSON | | | 2. SEX: Female | 3a. TIME OF DEATH: 12:50 PM | 3b. DATE OF DEATH (Month, Day, Yr): June 13, 2004 |
| 4. *SOCIAL SECURITY NUMBER: 229-38-0714 A | 5a. AGE—Last Birthday (Years): 69 | 5b. UNDER 1 YEAR: Months / Days | 5c. UNDER 1 DAY: Hours / Minutes | 6. DATE OF BIRTH (Mo, Day, Yr): January 27, 1935 | 7. BIRTHPLACE (City and State or Foreign Country): Norfolk, VA |
| 8a. WAS DECEDENT A U.S. VETERAN? No | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None | 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): Wm. J. Riley Memorial Residence | | 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): Larry W. Nelson | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker | | 12b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 13a. RESIDENCE—STATE: Indiana | 13b. COUNTY: Lake | 13c. CITY, TOWN, OR LOCATION: Hammond | | 13d. STREET AND NUMBER: 971 Wilcox Street | |
| 13e. ZIP CODE: 46320 | 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): 12 | College (1-4 or 5 +): | | | | |
| 18. FATHER'S NAME (First, Middle, Last): Earl Brietenbach | | 19. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Virginia Wright | | | |
| 20a. INFORMANT'S NAME (Type/Print): Larry W. Nelson | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 971 Wilcox St., Hammond, IN 46320 | | | 20c. Relationship: Husband | |
| 21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 16, 2004 Heritage Crematory | | | 21c. LOCATION—City or Town, State: Portage, IN | |
| 22a. EMBALMER'S NAME: Henry J. Blake | 22b. EMBALMER'S LICENSE NO: FD01019406 | 23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes | | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR: Eldon B Heyde | 24b. LICENSE NUMBER (of Licensee): FD01000857 | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LaHayne Funeral Home FH19400005 6955 Southeastern Ave., Hammond, IN 463 | | | |

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. METASTATIC ADENOCARCINOMA — Approximate Interval Between Onset and Death: 2 years

DUE TO (OR AS A CONSEQUENCE OF): b. UNKNOWN PRIMARY — 2 years

Conditions if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: PULMONARY EMBOLI

| 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 |
|---|---|---|

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: Alan Jones DO | 29c. MEDICAL LICENSE NO: 02000640 | 29d. DATE SIGNED (Month, Day, Year): June 14, 2004 |
|---|---|---|

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Alan Jones, DO, 929 Ridge Road, Munster, IN 46321

31. HEALTH OFFICER'S SIGNATURE: Susan M Bost D.O.

32. DATE FILED (Month, Day, Year): June 15 2004

| 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 |
|---|---|---|---|---|
| 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. | | | |

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR