INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3973-08 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
Beatrice Thompson		Female	10:30AM	November 20,2008

5. Social Security Number	6a. Age Yrs	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)	8. Birthplace (City And State Or Foreign Country)
350-12-8034	88					Aug. 25,1920	Oskaloosa,IA

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No Unknown ☐

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): 8607 Moraine

12. City Or Town, State, And Zip Code: Munster

13. County Of Death: Lake

14. Marital Status At Time Of Death: ☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name:

15a. (If Wife)Give Maiden Last Name:

16. Decedent's Usual Occupation: Teacher

17. Kind Of Business/Industry: Education

18. Residence – State	18a. County	18b. City Or Town
IN	Lake	Munster

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
8607 Moraine		46321	☒ Yes ☐ No

19. Decedent's Education — Please select education level:

20. Decedent Of Hispanic Origin: No — Please select Hispanic origin, if any:

21. Decedent's Race: White — Please select race:

22. Father's Name (First, Middle, Last): John Everet Garing

23. Mother's Name (First, Middle, Last): N.A. Garing

23a. Mother's Maiden Last Name: Barnhart

24. Informant's Name: George Thompson

24a. Relationship To Decedent: Son

24b. Mailing Address (Street And Number, City, State, Zip Code): 4275 Linden Tree Ln. Glenview, IL 60026

25. Place Of Disposition

25a. Method Of Disposition: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):

25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place): Kelly-Carroll Crematory

25c. Location – City, Town, And State: Gary,IN

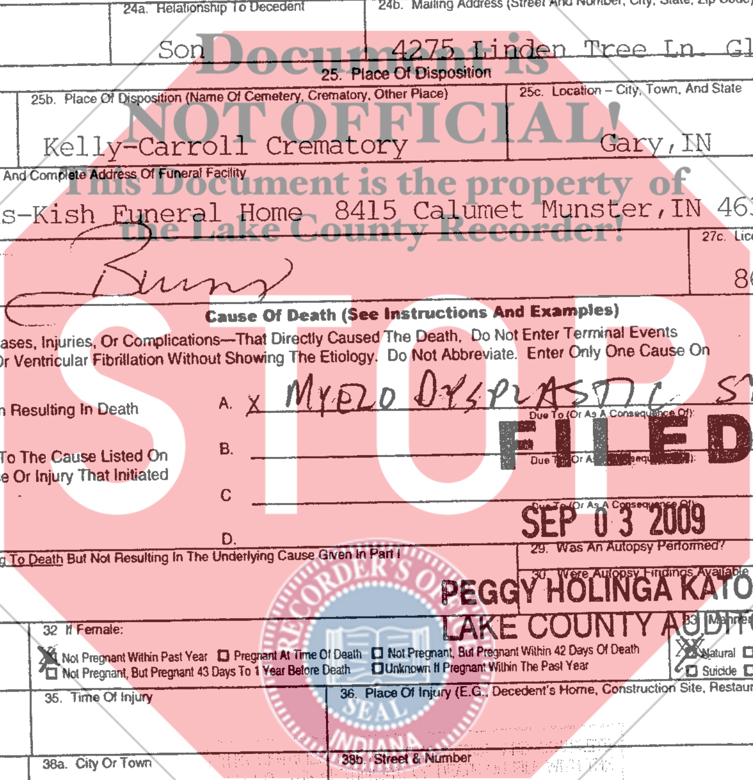
26. Was Coroner Contacted? ☒ Yes ☐ No

27. Name And Complete Address Of Funeral Facility: Burns-Kish Funeral Home 8415 Calumet Munster,IN 46321

27a. Funeral Home License Number: 3004968

27b. Signature Of Indiana Funeral Service Licensee: [signature]

27c. License Number (Of Licensee): 8601763



Cause Of Death (See Instructions And Examples)

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.

Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death) A. MYELO DYSPLASTIC SYNDROME — MONTHS

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

B. Due To (Or As A Consequence Of):

C. Due To (Or As A Consequence Of):

D. Due To (Or As A Consequence Of):

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? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☒ No ☐ Unknown

32. If Female: ☒ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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? ☐ Yes ☐ No

38. Location Of Injury - State:

38a. City Or Town:

38b. Street & Number:

38c. Apt. No.:

38d. Zip Code:

39 Describe How Injury Occurred:

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: [signature]

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: C.A. Foreit 1673 N. Cline Griffith,IN 46319 015283

44. License Number: 0200 1161

45. Date Certified: Nov. 21 ,2008

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: [signature] D.O.

49. For Registrar Only – Date Filed (Month/Day/Year): November 26.2008

FILED SEP 03 2009 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

2009 061583

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2009 SEP -8 AM 9:11 MICHAEL A. BROWN RECORDER

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