

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



Local No. 3102-09

State No.

1. Decedent's Legal Name (First, Middle, Last) <b>EMILY N. DANKO</b>				1a. Maiden Last Name (If Female) <b>DARLING</b>		2. Sex <b>F</b>	3. Time Of Death <b>4:15 AM</b>	4. Date Of Death (Month/Day/Year) <b>AUGUST 29, 2009</b>	
5. Social Security Number <b>[REDACTED]</b>	6a. Age - Yrs <b>84</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>DECEMBER 7, 1924</b>		8. Birthplace (City And State Or Foreign Country) <b>CHICAGO, ILLINOIS</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 checked="" 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 type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)	
11. Facility Name (If Not Institution, Give Street And Number) <b>SAINT ANTHONY MEDICAL CENTER</b>									
12. City Or Town, State, And Zip Code <b>CROWN POINT, INDIANA 46307</b>				13. County Of Death <b>LAKE</b>		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name <b>ERNEST J. DANKO</b>			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation <b>HOUSEWIFE</b>		17. Kind Of Business/Industry <b>OWN HOME</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>CROWN POINT</b>		18c. Apt. No.	18e. Zip Code <b>46307</b>	18f. Inside City Limit? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number <b>1831 EVERGREEN COURT</b>			19. Decedent's Education <b>HIGH SCHOOL</b>			20. Decedent Of Hispanic Origin <b>NO</b>			
21. Decedent's Race <b>WHITE</b>			22. Father's Name (First, Middle, Last) <b>JOHN DARLING</b>			23. Mother's Name (First, Middle, Last) <b>ANNA DARLING</b>		23a. Mother's Maiden Last Name <b>MORTON</b>	
24. Informant's Name <b>ERNEST J. DANKO</b>		24a. Relationship To Decedent <b>HUSBAND</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>1831 EVERGREEN COURT CROWN POINT IN 46307</b>					
25. Place Of Disposition									
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 CEMETERY</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>SOLAN PRUZIN FUNERAL HOME</b> <b>14 KENNEDY AVENUE SCHERERVILLE, INDIANA 46375</b>						
27a. Signature Of Indiana Funeral Service Licensee: <i>Dean L. Nag</i>						27c. License Number (Of Licensee) <b>8800657</b>			
28. 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.									
Immediate Cause (Final Disease Or Condition Resulting In Death) A. <b>Acute Myocardial Infarction</b>									
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. <b>Diabetes Mellitus</b>									
C. <b>Due To (Or As A Consequence Of)</b>									
D. <b>Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I</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 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)			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 type="checkbox"/> No			38. City Or Town			38c. Apt. No.		38d. Zip Code <b>46307</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) <b>CS</b>						
41. Signature Of Person Certifying Cause Of Death: <i>[Signature]</i>			42. Certifier (Check Only One) <input type="checkbox"/> Attending Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer <b>016428</b>						
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>A. MALIK M.D.</b> <b>8560 Broadway Merrillville, IN 46456</b>			44. License Number <b>34378A</b>			45. Date Certified <b>9-2-09</b>			
46. Additional Funeral Service Provider: <b>LAKE COUNTY AUDITOR</b>						48. Signature Of Local Health Officer: <i>Susan W. Burt</i>			
49. For Registrar Only - Date Filed (Month/Day/Year): <b>September 2, 2009</b>									