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il No. 829-04

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

E/PRINT IN MANENT ACK INK

1. DECEASED - NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
RICHARD	G.	ROTH, SR.	Male	8:00 A.M.	March 26, 2004

4. *SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
114-16-8504	79					March08,1925	BUFFALO New York

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	PLACE OF DEATH (Check only one; See instructions)
Yes	1947	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

EDENT

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. ANTHONY HOSPICE	CROWN POINT	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
Married	JANE BRAUN	DISTRICT CLAIM AGENT	CONRAIL

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	SCHERERVILLE	2033 ASHBURY LANE

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE— American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46375	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	4

ENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles ROTH	Sophia Weiss

ORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
PETER ROTH	1523 W. 94TH AVE.,, CROWN POINT, IN	Son

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	March 30, 2004 N.W. Ind. Cremation Services	Crown Point,, Indiana

POSITION

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
		☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James F. Burns	FD01009461	BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. End Stage Sepsis — DUE TO (OR AS A CONSEQUENCE OF): — Days

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

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No

USE OF ATH

COMMUNITY TITLE COMPANY
FILE NO. 42442

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.

RTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
George Babchuk	01031717	3/30/04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

DR. GEORGE BABCHUK 1121 S. INDIANA, CROWN POINT, IN 46307

ALTH FICER

31. HEALTH OFFICER'S SIGNATURE — 32. DATE FILED (Month, Day, Year)

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.
March 26, 2004	012977

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FILED SEP 21 2004 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1