



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-09-31-404-010,000-018

Local No.....

State No.....

1. Decedent's Legal Name (First, Middle, Last) EMMA B. FRALEY				1a. Maiden Last Name (If Female) Corder		2. Sex Female	3. Time Of Death 1:25 pm	4. Date Of Death (Month/Day/Year) November 15, 2009	
5. Social Security Number 317-14-8432	6a. Age - Yrs 83	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) January 5, 1926		8. Birthplace (City And State Or Foreign Country) Danville, Illinois	
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input 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 checked="" 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) VNA Horton Hospice Center									
12. City Or Town, State, And Zip Code Valparaiso, Indiana 46383				13. County Of Death Porter			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			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation Homemaker		17. Kind Of Business/Industry Home		
18. Residence - State Indiana		18a. County Lake		18b. City Or Town Hobart					
18c. Street And Number 626 South Washington Street				18d. Apt. No.		18e. Zip Code 46342		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education 10		20. Decedent Of Hispanic Origin No not Spanish/Hispanic/Latino			21. Decedent's Race White				
22. Father's Name (First, Middle, Last) Emilius G. Corder				23. Mother's Name (First, Middle, Last) Hazel M. Corder			23a. Mother's Maiden Last Name Claussen		
24. Informant's Name Barbara Fraley			24a. Relationship To Decedent Daughter		24b. Mailing Address (Street And Number, City, State, Zip Code) 5040 Honeysuckle Ave., Portage, IN 46368				
25a. Method Of Disposition. <input type="checkbox"/> Burial <input checked="" 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) Angelcrest Cremation Service			25c. Location - City, Town, And State Valparaiso, Indiana				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Rees Funeral Home, 600 West Old Ridge Rd. P.O. Box 488, Hobart, Indiana 46342					27a. Funeral Home License Number: FI183063069		
27b. Signature Of Indiana Funeral Service Licensee: <i>James J. Krause</i>					27c. License Number (Of Licensee): FD01006463				
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. Cardiac Arrhythmia B. Hepatocellular Carcinoma 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								Approximate Interval: Onset To Death	
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? <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 type="checkbox"/> No <input checked="" 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. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38d. Zip Code		38c. Apt. No.
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)				
41. Signature, Of Person Certifying Cause Of Death: <i>John P. Dolatowski MD</i>					42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Medical Examiner PEGGY HOLMES ATONA				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: John Dolatowski MD, 1441 S. Lake Park Avenue Hobart, IN 46342					44. License Number 01046155		45. Date Certified 11-17-09		
45. Additional Funeral Service Provider:					47. *Akas: 11-				
46. Signature of Local Health Officer: <i>Mary A. Babroka MD</i>					49. For Registrar Only - Date Filed (Month/Day/Year): November 17, 2009				



2009081052
RECORDED
INDEXED
DEC-17 2009
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER

FILED
DEC 07 2009

#11
CS
CR