* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 2920-07

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
ESTELLE C. DARRELL	Female	8:40pm	December 04, 2007

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)
[redacted]-1046	93			March 17, 1914	Gary, Indiana

8a. WAS DECEDENT A US VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES?	PLACE OF DEATH (Check only one See instructions)
No	N/A	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Hartsfield Village	Munster	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
Widowed	N/A	Homemaker	Home

13a. RESIDENCE STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Lake Station	2320 Riverside Drive

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)	
46405	☐ NO ☒ YES	☒ NO ☐ YES	USA	☒ NO ☐ YES	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Jacob Zvingilas	Agatha Baukus

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. RELATIONSHIP
Lee Darrell	1738 N. Lafayette Street, Griffith, IN 46319	Son

DISPOSITION

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)	December 7, 2007 Calvary Cemetery	Portage, IN 46368

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J Krause	FD01006463	☒ NO ☐ YES

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James T. Bailey	FD20100023	Rees Funeral Home, Olson Chapel Lic. # FH183005613 5341 Central Ave., Portage, Indiana, 46368

CAUSE OF DEATH

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 cause or condition resulting in death): a. Atherosclerotic heart disease

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

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.

I CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. DEC 0 6 2007

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hypertension, atrial fibrillation, Dementia

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

CERTIFIER

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occured at the time, date and place and due to the cause(s) stated.

☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occured at time, date and place, and due to the causes stated.

☐ CORONER On the basis of examination and investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Paik M.D.	01030770 A	12/6/07

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jay C.L. Paik MD 800 MacArthur Blvd., Munster IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

32. DATE FILED (Month, Day, Year): December 6 2007

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK (Yes or No)	34d. DESCRIBE HOW INJURY OCCURED

34e. PLACE OF INJURY - At home, farm street, factory, office building, etc (Specify) 021502

34f. LOCATION (Street and Number or Rural Route Number, City or Town and State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes, or No) If yes, specify driver, passenger, pedestrian, etc

SDH06-004 State Form 10110 (R5/1-99)

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