



45-11-16 204-005-000
036

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-07-09-403-028-000-023
45-07-21-102-010-000-025
011

Local No. 4003-09

State No.

1. Decedent's Legal Name (First, Middle, Last) DOUGLAS B. VENABLE				1a. Maiden Last Name (If Female)		2. Sex M	3. Time Of Death 7:20 PM	4. Date Of Death (Month/Day/Year) NOVEMBER 24, 2009		
5. Social Security Number 307-46-4807		6a. Age - Yrs 64	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year) FEB. 23, 1945		8. Birthplace (City And State Or Foreign Country) NAYLOR, MISSOURI	
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 checked="" type="checkbox"/> Emergency Department <input type="checkbox"/> 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) ST. MARGARET MERCY SOUTH CAMPUS										
12. City Or Town, State, And Zip Code DYER, INDIANA 46311					13. County Of Death LAKE		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 BRENDA K. VENABLE			15a. (If Wife) Give Maiden Last Name GEARHART		16. Decedent's Usual Occupation SUPERVISOR		17. Kind Of Business/Industry INLAND STEEL COMPANY			
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town SCHERERVILLE						
18c. Street And Number 1627 HOMAN DRIVE				18d. Apt. No.		18e. Zip Code 46315		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
19. Decedent's Education HIGH SCHOOL GRADUATE		20. Decedent Of Hispanic Origin NO		21. Decedent's Race WHITE						
22. Father's Name (First, Middle, Last) ROSEL VENABLE			23. Mother's Name (First, Middle, Last) WILLA T. VENABLE			23a. Mother's Maiden Last Name CROOK				
24. Informant's Name BRENDA K. VENABLE		24a. Relationship To Decedent SPOUSE		24b. Mailing Address (Street And Number, City, State, Zip Code) 1627 HOMAN DR. SCHERERVILLE, IN 46375						
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) SOLAN PRUZIN CREMATORY			25c. Location - City, Town, And State SCHERERVILLE, INDIANA					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility SOLAN PRUZIN FUNERAL HOME 14 KENNEDY AVE. SCHERERVILLE, IN 46375								
27b. Signature Of Indiana Funeral Service Licensee: <i>Dea L. Wag</i>						27c. License Number (Of Licensee): FD 880057				
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. <input checked="" type="checkbox"/> Ischemic Refractory Ventricular Fibrillation 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. Hypertensive Heart disease C. D.										
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. Coronary Artery disease, Premature Ventricular Contractions, Dyslipidemia						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 type="checkbox"/> No <input checked="" type="checkbox"/> Unknown				
32. If Female: <input 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 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, Workplace, etc.)				37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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: <input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) PEGGY HOINGA KATONA LAKE COUNTY AUDITOR				
41. Signature Of Person Certifying Cause Of Death: <i>Shashidhar Divalareni</i>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: SHASHIDHAR DIVALARENI M.D. 9116 Columbia Ave Munster IN 46321						44. License Number 01040607		45. Date Certified Nov 25th 2009		
46. Additional Funeral Service Provider:						47. *Akas:				
48. Signature Of Local Health Officer: <i>Susan J Best D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year): November 30, 2009				



2010 002715
2010 JAN 15 4:10:09
STATE OF INDIANA
FILED FOR RECORDER
LAKE COUNTY RECORDER
APPROXIMATE INTERVAL: ONSET TO DEATH

FILED
JAN 15 2010
PEGGY HOINGA KATONA
LAKE COUNTY AUDITOR