ENTION ESTATE: The Social Security # is requested by this state agency in order to e its statutory responsibility. Disclosure is ary and there will be no penalty for refusal.

al No. 2579-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

E/PRINT IN MANENT CK INK

1. DECEASED NAME (First, Middle, Last): Mary Ellen O'Hare
2. SEX: Female
3a. TIME OF DEATH: 1:25 PM
3b. DATE OF DEATH (Month, Day, Year): Oct. 27, 2007
4. *SOCIAL SECURITY NUMBER: 312-50-3564
5a. AGE – Last Birthday (Years): 84
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): July 26, 1923
7. BIRTHPLACE (City and State or Foreign Country): Peoria, IL
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NA
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

EDENT

9b. FACILITY NAME (If not institution, give street and number): Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): NA
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Farmer
12b. KIND OF BUSINESS/INDUSTRY: Agriculture
13a. RESIDENCE — STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Dyer
13d. STREET AND NUMBER: 31 Illinois St.
13e. ZIP CODE: 46311
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5 +): +4

NTS

18. FATHER'S NAME (First, Middle, Last): Charles Carroll Reardon
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ryan

RMANT

20a. INFORMANT'S NAME (Type/Print): Bonnie O'Hare
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code): 31 Illinois St., Dyer, IN 46311
20c. Relationship: Daughter

OSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 31, 2007 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN
22a. EMBALMER'S NAME: Marjorie Kunch
22b. EMBALMER'S LICENSE NO.: FD20500007
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD20500007
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn Funeral Home FH19900051 8178 S. Cline Ave., Schererville, IN

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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. Acute Urosepsis
DUE TO (OR AS A CONSEQUENCE OF):
b. Urinary Tract Infection
DUE TO (OR AS A CONSEQUENCE OF):
c. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Acute Gastrointestinal Bleeding, Disseminated Intravascular Coagulopathy
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or No): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): No

TIFIER

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 01019059
29d. DATE SIGNED (Month, Day, Year): 10-29-07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Charles Egnatz 1326 W. US 30 Schererville, IN 46375

LTH CER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.
32. DATE FILED (Month, Day, Year): October 30, 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 OCCURRED:
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.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF A CERTIFICATE ... LAKE COUNTY HEALTH DEPARTMENT

2010 015720

2010 MAR 18 AM 9:43

FILED MAR 18 2010

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PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

$11 CS