538515

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 000176 45-03-28-351-035.000-024 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
Lillian Phillips	N/A	Female	7:40	July 14,2010

5. Social Security Number	6a. Age – Yrs	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)	8. Birthplace (City And State Or Foreign Country)
315-30-7800	81					Feb.28,1929	Union Spring, AL

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☒ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): Lake County Nursing & Rehab Center

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
East Chicago, IN	Lake	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
N/A	N/A	Homemaker	Own Home

18. Residence – State	18a. County	18b. City Or Town
IN	Lake	Crown Point

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
1011 Freedom Circle		46307	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
N/A	No	Black

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
N/A	N/A	N/A

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
Inell Simmons	Step-daughter	1011 Freedom Circle, Crown Point, IN 46307

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	Calvery Crematory	Portage, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	Ridgelawn Funeral Home, 4201 W. Ridge RD, Gary, IN 4640	FH1020007

27b. Signature Of Indiana Funeral Service Licensee: [signature]

27c. License Number (Of Licensee): FD29400049

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.

			Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A.	Complication of Kidney Failure	
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.	Due To (Or As A Consequence Of): Multiple Myeloma	
	C	Due To (Or As A Consequence Of):	
	D.	Due To (Or As A Consequence Of):	

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? ☐ Yes ☐ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☐ No ☐ Unknown

32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

JUL 19 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: [signature]

42. Certifier (Check Only One) ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death	44. License Number	45. Date Certified
Okolocha Medical 2054 Cleveland St. Gary, In 46404	01041856	7-15-10

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: [signature] 002916

49. For Registrar Only – Date Filed (Month/Day/Year): 7/19/10

IVRA-20 (7/05)

State Form 10110 (R7/9-07) ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to purs

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT