45-07-10-482-007.000-023

INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 520

CERTIFICATE OF DEATH

Jun 21, 1993 Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Anna P. Seren

2 SEX: Female

3a TIME OF DEATH: 7:30 A M

3b DATE OF DEATH (Month, Day, Yr.): June 20, 1993

4 SOCIAL SECURITY NUMBER: 313-72-9566

5a AGE—Last Birthday (Years): 56

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day. Yr): April 20, 1937

7 BIRTHPLACE (City and State or Foreign Country): Algoma, West Virginia

8a WAS DECEDENT A U.S. VETERAN? no

8b YEAR LAST SERVED IN U.S. ARMED FORCES? none

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): St. Margaret-Mercy Health Care Centre

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Joseph Seren

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker

12b KIND OF BUSINESS/INDUSTRY: Own Home

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Hammond

13d STREET AND NUMBER: 3842 Robin Hood Lane

13e ZIP CODE: 46323

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Marshall Watkins

19 MOTHER'S NAME (First, Middle, Maiden Surname): Gillie Clark

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mr. Joseph Seren

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3842 Robin Hood Lane Hammond, IN 46323

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 23, 1993 Chapel Lawn Memorial Gardens

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: John C. Ault

22b EMBALMER'S LICENSE NO.: FD01013507

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: John C. Ault

24b LICENSE NUMBER (of Licensee): FD01013507

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. COMA — Approximate Interval Between Onset and Death: 7 DAYS

DUE TO (OR AS A CONSEQUENCE OF)
b. BRAIN METASTASIS — 2 MONTHS

DUE TO (OR AS A CONSEQUENCE OF)
c. CARCINOMA OF BREAST — 2 YEARS

DUE TO (OR AS A CONSEQUENCE OF)
d.

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

RECEIVED FOR RECORD JUL 20 AM 8 41 — RECORDED FOR RECORD JUL 20 AM 8 41

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: ANEMIA, PULMONARY METASTASIS

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

CERTIFIER

29a CERTIFIER (Check only one): [X] 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] M.D.

29c MEDICAL LICENSE NO.: 29974

29d DATE SIGNED (Month, Day, Year): June 6 1993

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Mahendra M. Shah, 5500 Hohman Ave., Hammond, In., 46320

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.

32 DATE FILED (Month, Day, Year): June 21, 1993

CORONER USE ONLY

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.

FILED JUL 30 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 053999

$11 CS CA

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1