INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 467-09 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)
JEROME G. WHITE	-	MALE	5:00 A.M.	FEBRUARY 17, 2009

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)
387-12-6581	88					JUNE 19, 1920	CASSIAN, WISCONSIN

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): SPRING MILL HEALTH CARE CENTER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
MERRILLVILLE, INDIANA 46410	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
FRANCES M. WHITE	SHOFROTH	CO-OWNER INSURANCE AGENT	INSURANCE AGENCY

18. Residence – State	18a. County	18b. City Or Town	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
INDIANA	LAKE	HIGHLAND		46322	☒ Yes ☐ No

18c. Street And Number: 10012 WILDWOOD LANE

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
HIGH SCHOOL GRADUATE Please select education level:	NO Please select Hispanic origin, if any:	WHITE Please select race:

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
ALBERT V. WHITE	LILLIAN WHITE	JENSEN

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
FRANCES M. WHITE	WHITE	10012 WILDWOOD LANE, HIGHLAND, INDIANA 46322

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):	FEBRUARY 20, 2009 CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, INDIANA

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	ANTHONY & DZIADOWICZ FUNERAL HOME 9445 CALUMET AVENUE MUNSTER, INDIANA 46321	83102916

27b. Signature Of Indiana Funeral Service Licensee: Larry D. Anthony

27c. License Number (Of Licensee): 01001447

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. Myocardial Infarction Due To (Or As A Consequence Of):	
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. Coronary artery disease Due To (Or As A Consequence Of):	
	C Due To (Or As A Consequence Of):	
	D.	

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 ☐ 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

39. Describe How Injury Occurred

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

41. Signature, Of Person Certifying Cause Of Death:

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
JOSE L. AGUSTI, M.D. 2640 HAMSTROM RD, PORTAGE, IN 46368	01061624	FEB. 18, 2009

46. Additional Funeral Service Provider:

47. *Akas: #35805

48. Signature of Local Health Officer: Susan D Bast D.O.

49. For Registrar Only – Date Filed (Month/Day/Year): February 20, 2009

State Form 10110 (R7/9-07) ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10

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FILED
JUL 19 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR