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PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

45-11-15-229-003-000-036

138 379 TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Form with fields for 1. DECEASED-NAME, 2. SEX, 3a. TIME OF DEATH, 3b. DATE OF DEATH, 4. SOCIAL SECURITY NUMBER, 5a. AGE, 5b. UNDER 1 YEAR, 5c. UNDER 1 DAY, 6. DATE OF BIRTH, 7. BIRTHPLACE, 8a. WAS DECEDENT A U.S. VETERAN?, 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?, 9a. PLACE OF DEATH, 9b. FACILITY NAME, 9c. CITY, TOWN, OR LOCATION OF DEATH, 9d. COUNTY OF DEATH, 10. MARITAL STATUS, 11. SURVIVING SPOUSE, 12a. DECEDENT'S USUAL OCCUPATION, 12b. KIND OF BUSINESS/INDUSTRY, 13a. RESIDENCE-STATE, 13b. COUNTY, 13c. CITY, TOWN, OR LOCATION, 13d. STREET AND NUMBER, 13e. ZIP CODE, 13f. INSIDE CITY LIMITS, 14. CITIZEN OF WHAT COUNTRY?, 15. WAS DECEDENT OF HISPANIC ORIGIN?, 16. RACE, 17. DECEDENT'S EDUCATION, 18. FATHER'S NAME, 19. MOTHER'S NAME, 20a. INFORMANT'S NAME, 20b. MAILING ADDRESS, 20c. Relationship, 21a. METHOD OF DISPOSITION, 21b. DATE AND PLACE OF DISPOSITION, 21c. LOCATION, 22a. EMBALMER'S NAME, 22b. EMBALMER'S LICENSE NO., 23. WAS DEATH REPORTED TO CORONER?, 24a. SIGNATURE OF FUNERAL DIRECTOR, 24b. LICENSE NUMBER, 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME, 26. PART I. Enter the diseases, injuries, or complications that caused the death, 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?, 28a. WAS AN AUTOPSY PERFORMED?, 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?, 29a. CERTIFIER, 29b. SIGNATURE AND TITLE OF CERTIFIER, 29c. MEDICAL LICENSE NO., 29d. DATE SIGNED, 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH, 31. HEALTH OFFICER'S SIGNATURE, 32. DATE FILED, 33. MANNER OF DEATH, 34a. DATE OF INJURY, 34b. TIME OF INJURY, 34c. INJURY AT WORK, 34d. DESCRIBE HOW INJURY OCCURRED, 34e. PLACE OF INJURY, 34f. LOCATION, 34g. DATE PRONOUNCED DEAD, 34h. MOTOR VEHICLE ACCIDENT.

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