



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-19.25-181-007.000-009

Local No. 3560-10

State No.

1. Decedent's Legal Name (First, Middle, Last) Joan Hemmah				1a. Maiden Last Name (If Female) Bruhl		2. Sex Female	3. Time Of Death 02:55 PM	4. Date Of Death (Month/Day/Year) October 6, 2010		
5. Social Security Number 333-36-3691	6a. Age - Yrs 67	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) October 5, 1943		8. Birthplace (City And State Or Foreign Country) Chicago, IL		
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street And Number) St Anthony Medical Center										
12. City Or Town, State, And Zip Code Crown Point				13. County Of Death Lake		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name Bernard Hemmah			15a. (If Wife) Give Maiden Last Name Hemmah		16. Decedent's Usual Occupation Seamstress		17. Kind Of Business/Industry Park Dept.			
16. Residence - State IN		16a. County Lake		16b. City Or Town Lowell		16c. Street And Number 1668 Canary Ln.		18d. Apt. No.	18e. Zip Code 46356	
18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		19. Decedent's Education 9 - 12th, No diploma		20. Decedent Of Hispanic Origin No		21. Decedent's Race Caucasian				
22. Father's Name (First, Middle, Last) Roy E. Bruhl				23. Mother's Name (First, Middle, Last) Frieda Bruhl		23a. Mother's Maiden Last Name Roesler				
24. Informant's Name Bernard Hemmah			24a. Relationship To Decedent Husband		24b. Mailing Address (Street And Number, City, State, Zip Code) 1668 Canary Ln., Lowell, IN 46356					
25a. Method Of Disposition: <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) Geisen Cremation Centre			25c. Location - City, Town, And State Crown Point IN					
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Sheets Funeral Home & Cremation Services 604 E. Commercial Ave., Lowell, IN 46356								
27b. Signature Of Indiana Funeral Service Licensee: <i>Ken Sheets</i>						27c. Funeral Home License Number: FH83004277 FD08900045				
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. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Vascular collapse</u> B. <u>Due to arteriosclerotic heart and vascular disease</u> C. _____ D. _____ Approximate Interval: Onset To Death Unknown										
28. 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown				
32. If Female: <input type="checkbox"/> Not Pregnant In Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, Not Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined				37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury OCT 13 2010		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)				38. Apt. No.		38d. Zip Code
38. Location Of Injury - State		38a. City Or Town		38b. State		38c. Apt. No.		38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: <i>P.J. Adams</i>						42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: P.J. Adams, Chief Investigator 2900 West 93rd Avenue, Crown Point, Indiana 46307						44. License Number N/A		45. Date Certified Oct. 12, 2010		
46. Additional Funeral Service Provider:						47. *Akas:				
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year): <i>October 12, 2010</i>				