



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

TRUE COPY OF RECORD OF
REGISTRATION ON FILE AT
LA PORTE COUNTY HEALTH
DEPARTMENT

Local No. **1043** Parcel # **45-09-16-457-008-000-021** State No. **021**

1. Decedent's Legal Name (First, Middle, Last) Patricia H. Karriman				1a. Maiden Last Name (If Female) Davis		2. Sex Female	3. Time Of Death 1:00 pm	4. Date Of Death (Month/Day/Year) December 25, 2008	
5. Social Security Number 307-60-3622		5a. Age—Yrs 55	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) May 03, 1953		8. Birthplace (City and State or Foreign Country) Gary, Indiana
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input 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 Memorial Health Center									
12. City or Town, State, and Zip Code Michigan City IN 46360					13. County Of Death LaPorte			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 David F. Karriman Sr.			15a. (If Wife) Give Maiden Name		16. Decedent's Usual Occupation Bookkeeper		17. Kind Of Business/Industry Retail Industry		
18. Residence — State IN		18a. County Porter			18b. City Or Town Chesterton				
18c. Street And Number 198 E. 900 N.				18d. Apt. No.		18e. Zip Code 46304		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education High school graduate or GED completed			20. Decedent of Hispanic Origin? No, not Spanish/Hispanic/Latino		21. Decedent's Race White				
22. Father's Name (First, Middle, Last) John F. Davis				23. Mother's Name (First, Middle, Last) Marian Davis			23a. Mother's Maiden Last Name Hockett		
24. Informant's Name David F. Karriman Sr.		24a. Relationship To Decedent Spouse		24b. Mailing Address (Street And Number, City, State, Zip Code) 198 E. 900 N. Chesterton, Indiana 46304					
25. Place of Disposition									
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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) Chesterton Cemetery			25c. Location — City, Town, And State Chesterton, IN			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Edmonds & Evans Funeral Home 517 Broadway Chesterton, IN 46304					27a. Funeral Home License Number FH8300875		
27b. Signature Of Indiana Funeral Service Licensee: 						27c. License Number (Of Licensee) FD20800032			
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. Stage IV Bile duct Cancer 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. _____ Due To (Or As A Consequence Of):									
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 1.						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 type="checkbox"/> No	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within 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, But Pregnant 43 Days Or More Before Death <input type="checkbox"/> Unknown If Pregnant Within Past Year			33. Manner Of Death: <input 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				
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
38. Location Of Injury — State		38a. City Or Town		38b. Street & No.		38c. Apt. No.	38d. Zip Code 116 CS RA		
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 						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death Minessh Patel M.D. 8733 W. 400 N., Michigan City, Indiana 46360						44. License Number 01040384 A		45. Date Certified 12/30/08	
46. Additional Funeral Service Provider:						47. Akas:			
48. Signature of Local Health Officer: 						49. For Registrar Only — Date Filed (Month/Day/Year): 2983 A DEC 30 2008			