

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

Local No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

INFORMANTS

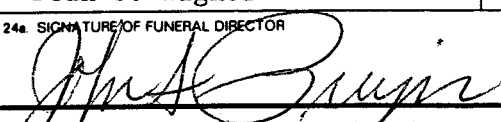

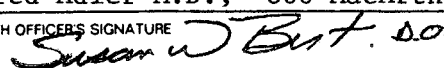
INFORMANT

DISPOSITION

USE OF  
ATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>L. MAXINE SUMMERS</b>				2. SEX <b>Female</b>	3a. TIME OF DEATH <b>1:18 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>March 15, 2007</b>
4. *SOCIAL SECURITY NUMBER <b>316-24-9356</b>		5a. AGE—Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>October 14, 1926</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>no</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>na</b>	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) <b>MUNSTER MED-INN</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Vern E. Summers</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Housewife</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Griffith</b>		13d. STREET AND NUMBER <b>231 N. Indiana</b>
13e. ZIP CODE <b>46319</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify: Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>2010</b>
18. FATHER'S NAME (First, Middle, Last) <b>Vernon Perry</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Brannon</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Vern E. Summers</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>231 N. Indiana, Griffith, Indiana 46319</b>		20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>March 21, 2007 SOLAN-PRUZIN CREMATORY</b>		21c. LOCATION—City & County, State <b>Schererville, Indiana</b>		
22a. EMBALMER'S NAME <b>Dean G. Wagner</b>		22b. EMBALMER'S LICENSE NO. <b>FD 08800057</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) <b>FD# 01007231</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>SOLAN-PRUZIN FUNERAL HOME FH#83002893 14 Kennedy Ave., Hammond, Ind. 46324</b>		
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. <b>Cerebral vascular accident</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Failure to receive epinephrine</b> DUE TO (OR AS A CONSEQUENCE OF): d.						
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I			27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>na</b>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>no</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>na</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 				29c. MEDICAL LICENSE NO. <b>01019251</b>	29d. DATE SIGNED (Month, Day, Year) <b>March 20, 2007</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Fred Adler M.D., 800 MacArthur, Munster, Indiana 46321</b>						
31. HEALTH OFFICER'S SIGNATURE 				32. DATE FILED (Month, Day, Year) <b>March 21, 2007</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) <b>Oct 14 2010</b>	34b. TIME OF INJURY <b>1:14 PM</b>	34c. INJURY AT WORK? (Yes or no) <b>no</b>		
		34d. DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. <b>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR MAR 21 2007</b>				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>055381</b>				