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

HAMILTON COUNTY HEALTH DEPARTMENT

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

State No.

Burial No: 9955

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

2010 061758

1. DECEASED-NAME (First, Middle, Last): Catherine Peer
2. SEX: Female
3a. TIME OF DEATH: 5:13 PM
3b. DATE OF DEATH Month, Day Yr.): November 26, 2007
4. SOCIAL SECURITY NUMBER: 305-52-4634
5a. AGE-Last Birthday (Years): 48
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 27, 1959
7. BIRTHPLACE (City and State or Foreign Country): Gary Indiana
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Vincent Carmel Hospital 13500 N. Meridian Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Carmel
9d. COUNTY OF DEATH: Hamilton
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John Peer
12a. DECEDENT's USUAL OCCUPATION (One kind of work done during most of working life Do not use retired): Pharmaceutical
12b. KIND OF BUSINESS/INDUSTRY: Medical
13a. RESIDENCE-STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 625 E. South Street
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican Puerto Rican, etc.)
16. RACE-American Indian, Black, White, etc (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0, 12): 12; College (1-4 or 5+): 2
18. FATHER'S NAME (First Middle, Last): Charles Mares
19. MOTHER'S NAME (First Middle, Maiden Surname): Carole Saball
20a. INFORMANT'S NAME (Type/Print): John Peer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 625 E. South Street Crown Point, IN 46307
20c. Relationship: Husband
21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other piece): December 01, 2007 St. Mary's Cemetery
21c. LOCATION-City or Town, State: Crown Point, Indiana
22a. EMBALMER'S NAME: Evans, Rachel
22b. EMBALMER'S LICENSE NO.: FD20700035
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Pat Cooley
24b. LICENSE NUMBER (of Licenses): FD20700092
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Flanner & Buchanan Funeral Center-Market St. FH10500018 Indianapolis, Indiana 46202

26. PART 1. 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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Sepsis (Right)
DUE TO (OR AS A CONSEQUENCE OF):
b. Ischemic Necrosis Colon / Terminal Ileum
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part 1: Respiratory Failure, Renal Failure
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: Margaret Inman MD
29c. MEDICAL LICENSE NO: 01037705A
29d. DATE SIGNED (Month, Day, Year): 12/6/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Margaret Inman MD 11725 Illinois, Carmel IN 46038
31. HEALTH OFFICERS SIGNATURE: Charles Harris, MD
32. DATE FILED (Month, Day, Year): DEC 07 2007

FILED
055541
OCT 22 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY-At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

CS
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SDH06-004 State Form 1011 0 (R5/1 99)

12/07

Charles Harris, MD
Hamilton County Health Officer

DATE DEC 07 2007

This photocopy is a true copy of the record on file with the Hamilton County Health Dept.