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PORTER COUNTY
CERTIFICATE OF DEATH

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

45-07-39-429-015-000 002

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

1. DECEASED—NAME (First, Middle, Last) NONA JOANNE FIEGLE		2. SEX Female	3a. TIME OF DEATH 3:55 A M	3b. DATE OF DEATH (Month, Day, Year) May 13, 2007
4. SOCIAL SECURITY NUMBER 311-28-1310	5a. AGE—Last Birthday (Years) 76	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) July 29, 1930
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? -	9b. FACILITY NAME (If not institution, give street and number) Regency Hospital Company	9c. CITY, TOWN, OR LOCATION OF DEATH Portage	9d. COUNTY OF DEATH Porter
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Verle Fiegle	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher	12b. KIND OF BUSINESS/INDUSTRY Public Schools	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Griffith	13d. STREET AND NUMBER 434 N. Cline Avenue	
13e. ZIP CODE 46319	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary, Secondary (0-12) 12 College (1-4 or 5+) 5+		18. FATHER'S NAME (First, Middle, Last) George Mueller		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Wittmer		20a. INFORMANT'S NAME (Type/Print) Verle Fiegle		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 434 N. Cline Avenue Griffith, IN 46319		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) May 16, 2007 Calvary Cemetery		21c. LOCATION—City or Town, State Portage, Indiana
22a. EMBALMER'S NAME: Ronald J. Mesarch		22b. EMBALMER'S LICENSE NO. FDO1005912		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>		24b. LICENSE NUMBER (of Licensee) FDO1005912		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410
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. CARDIOPULMONARY ARREST		
DUE TO (OR AS A CONSEQUENCE OF):		b. HYPERTENSIVE HEART DISEASE		
DUE TO (OR AS A CONSEQUENCE OF):		c. CONGESTIVE HEART FAILURE		
DUE TO (OR AS A CONSEQUENCE OF):		d. HYPERTENSION		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. CEREBROVASCULAR ACCIDENT. CHRONIC RIGHT LEG ULCER. DIABETES MELITUS TYPE II.				
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) <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 <i>Sebastian...</i>		29c. MEDICAL LICENSE NO. 01033796 A		29d. DATE SIGNED (Month, Day, Year) 05/21/2007
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Baghar Mohideen M.D. 502 Wall Street Suite 101 Valparaiso, IN.				
31. HEALTH OFFICER'S SIGNATURE <i>Way A. Bobroka MD</i>				32. DATE FILED (Month, Day, Year) May 21, 2007
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK (Yes or No)
34a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34d. LOCATION (Street and Number or Rural Route Number, City or Town, State) FILED DEC 07 2010 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian.		

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

2010 OCT -7 AM 10:24
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