

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 311-01

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Aurora A. Fassoth				2 SEX Female	3a TIME OF DEATH 8:40 P.M.	3b DATE OF DEATH (Month, Day, Yr.) February 6, 2001	
4 *SOCIAL SECURITY NUMBER 313-62-0616		5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) Dec. 22, 1925		7 BIRTHPLACE (City and State or Foreign Country) Philippines
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 <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			
9b FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake				9c CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Vernon Fassoth		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Griffith		13d STREET AND NUMBER 1401 S. Broad St.	
13e ZIP CODE 46319		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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+) 2010					
18 FATHER'S NAME (First, Middle, Last) Gregorio Amio				19 MOTHER'S NAME (First, Middle, Maiden Surname) Dalmacea Razon			
20a INFORMANT'S NAME (Type/Print) Vernon Fassoth			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 S. Broad St., Griffith, Ind., 46319			20c Relationship Husband	
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) February 12, 2001 Regional Cremation Service			21c LOCATION—City or Town, State Munster, Indiana		
22a EMBALMER'S NAME Edgar C. Gleim		22b EMBALMER'S LICENSE NO. FDO 1016173		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>David R. Peterson</i>		24b LICENSE NUMBER (of Licensee) FDO 8601585		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 19900008			
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. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. pulmonary embolism 2112-02-03 1 day DUE TO (OR AS A CONSEQUENCE OF)							
b. _____ DUE TO (OR AS A CONSEQUENCE OF)							
c. _____ DUE TO (OR AS A CONSEQUENCE OF)							
d. _____ DUE TO (OR AS A CONSEQUENCE OF)							
27 PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I. renal failure							
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a WAS AN AUTOPSY PERFORMED? (Yes or no)		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>[Signature]</i>				29c MEDICAL LICENSE NO. 101035956		29d DATE SIGNED (Month, Day, Year) 2-6-01	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MAHER, JAM, 8668 BROADWAY, Merrillville Ind, 46410							
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32 DATE FILED (Month, Day, Year) February 12, 2001	
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) DEC 23 2010		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no) NO	
34d DESCRIBE HOW INJURY OCCURRED FILED		34e PLACE OF INJURY—At home, farm, street, etc. (Specify) PEGGY HULING KATONA LAKE COUNTY AUDITOR		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 056870			
34g DATE PRONOUNCED DEAD (Month, Day, Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			