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

Local No. 1287-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 45-08-28-126-025-000-004

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED–NAME (First, Middle, Last): Doris T. Champion
- 2. SEX: Female
- 3a. TIME OF DEATH: 5:34 A M
- 3b. DATE OF DEATH (Month, Day, Yr.): May 18, 2003
- 4. *SOCIAL SECURITY NUMBER: 307-60-3954
- 5a. AGE–Last Birthday (Years): 63
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo. Day, Yr): August 31, 1939
- 7. BIRTHPLACE (City and State or Foreign Country): Yazoo, MS
- 8a. WAS DECEDENT A U.S. VETERAN?: No
- 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NA
- 9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
- 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): Widowed
- 11. SURVIVING SPOUSE (If wife, give maiden name): none
- 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: IN
- 13b. COUNTY: Lake
- 13c. CITY, TOWN, OR LOCATION: Gary
- 13d. STREET AND NUMBER: 3790 Fillmore Street
- 13e. ZIP CODE: 46408
- 13f. INSIDE CITY LIMITS: [ ] No [X] Yes
- 13g. ON A FARM?: [X] No [ ] Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
- 16. RACE–American Indian, Black, White, etc. (Specify): Black
- 17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Clarence Robinson
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Dennis

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Derian C. Taylor
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Foxmore Ct. Sterling, VA 20165
- 20c. Relationship: Daughter

DISPOSITION

- 21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 23, 2003 Evergreen Memorial Park
- 21c. LOCATION–City or Town, State: Hobart, IN
- 22a. EMBALMER'S NAME: Sherman G. Banks III
- 22b. EMBALMER'S LICENSE NO.: FD 01016254
- 23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Sherman G. Banks III
- 24b. LICENSE NUMBER (of Licensee): FD 01016254
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home FH19600034 4209 Grant St, Gary, IN, 46408

CAUSE OF DEATH

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.

		Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	Metastatic Cancer Unknown Primary	Unknown
DUE TO (OR AS A CONSEQUENCE OF)	b	Pneumonia	1 wk
DUE TO (OR AS A CONSEQUENCE OF)	c	Multiorgan failure	1 wk
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. 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): 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

CERTIFIER

- 29a. CERTIFIER (Check only one):
  - [X] 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: Vijay P. Shah
- 29c. MEDICAL LICENSE NO.: 01044106
- 29d. DATE SIGNED (Month, Day, Year): 5/20/2003
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): VIJAY P. SHAH, MD 200 E 86th Pl. MERRILLVILLE IN 46410

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Susan W. Burt D.O.
- 32. DATE FILED (Month, Day, Year): May 23, 2003

- 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.:

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY ... MAY 23 2003

FILED MAR 04 2011 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

000732

2011 MAR -4 AM 10:31 FILED FOR RECORD LAKE COUNTY RECORDER

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