

**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**



Local No. 1419-09

State No. _____

1. Decedent's Legal Name (First, Middle, Last) ERMA M. DELLENBACH				1a. Maiden Last Name (If Female) FREEMAN		2. Sex FEMALE	3. Time Of Death 10:44 A.M.	4. Date Of Death (Month/Day/Year) MARCH 29, 2009		
5. Social Security Number 310-12-6295		6a. Age - Yrs 88	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) DECEMBER 29, 1921		8. Birthplace (City And State Or Foreign Country) SPENCER, INDIANA	
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street And Number) ST. MARGARET MERCY										
12. City Or Town, State, And Zip Code HAMMOND, INDIANA 46320				13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name ELMER L. DELLENBACH, JR.			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation SWITCH BOARD OPERATOR		17. Kind Of Business/Industry ROOFING			
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town HAMMOND		18c. Street And Number 924-169th PLACE	18d. Apt. No.	18e. Zip Code 46324	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education HIGH SCHOOL GRADUATE		20. Decedent Of Hispanic Origin NO		21. Decedent's Race WHITE						
22. Father's Name (First, Middle, Last) VIRGIL RAY DUNCAN				23. Mother's Name (First, Middle, Last) NELLIE FREEMAN			23a. Mother's Maiden Last Name FREEMAN			
24. Informant's Name ELMER L. DELLENBACH, JR.		24a. Relationship To Decedent HUSBAND		24b. Mailing Address (Street And Number, City, State, Zip Code) 924-169th PLACE, HAMMOND, INDIANA 46324						
25a. Method Of Disposition: <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) SOLAN-PRUZIN CREMATORY			25c. Location - City, Town, And State SCHERERVILLE, INDIANA					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility SOLAN-PRUZIN FUNERAL HOME & CREMATORY 7109 CALUMET AVENUE, HAMMOND, INDIANA 46324					27a. Funeral Home License Number: FH83002893			
27b. Signature Of Indiana Funeral Service Licensee: <i>Dea L Wag</i>				27c. License Number (Of Licensee): FD8800057						
NOT OFFICIAL!										
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28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Cardio pulmonary failure</u> B. <u>Septic shock</u> C. <u>perforated colon/peritonitis</u> D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last										
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						30. Were Autopsy Findings Available To The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Coroner's Determination					
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, etc.) COMMUNITY TITLE COMPANY			37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
38. Location Of Injury - State INDIANA				38a. City Or Town LAKE COUNTY		38b. Street & Number PEGGY HOLINGA KATONA		38c. Apt. No.		38d. Zip Code LAKE COUNTY AUDITOR
39. Describe How Injury Occurred FILE NO 144351						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) #11 CM CA				
41. Signature Of Person Certifying Cause Of Death: <i>Asim Chughtai M.D.</i>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: DR ASIM CHUGHTAI MD 222 E Douglas St. Hammond IN 46324						44. License Number 01634618A		45. Date Certified APRIL 1, 2009		
46. Additional Funeral Service Provider:						47. *Akas:				
48. Signature Of Local Health Officer: <i>Susan W But</i>						49. For Registrar Only - Date Filed (Month/Day/Year): 000326		April 3, 2009		