INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-18-18-126-022-000-014

Local No 000725 **EDR No** 000000185895 **State No** 009868

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
CARRIE L BOUYER	KINARD	FEMALE	06:32 PM	02/25/2011

5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date of Birth (Month/Day/Year)	8. Birthplace (City and State or Foreign Country)
327-30-7039	76	Months	Days	Hours	Minutes	06/02/1934	CHICAGO, IL

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☒ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival

10a. If Death Occurred Somewhere Other Than A Hospital ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number): ST MARY MEDICAL CENTER INC

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
HOBART, IN, 46342	LAKE	☐ Married ☐ Married, But Separated ☒ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife)Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind of Business/Industry
		TELEPHONE OPERATOR	UNIVERSITY

18. Residence - State	18a. County	18b. City Or Town
INDIANA	LAKE	GARY

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
4208 WEST 21ST PLACE		46404	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
HIGH SCHOOL GRADUATE OR GED COMPLETED	NOT HISPANIC	Black or African American

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
CLAUDE KINARD	EMILY KINARD	WILLIAMS

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
PAT HARDAWAY	SISTER	4208 WEST 21ST PLACE, GARY, IN 46404

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	RIDGELAWN	GARY, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	RIDGELAWN FUNERAL HOME, INC., 4201 W. RIDGE ROAD, GARY, IN 46408	FH10200007

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
SHELIA C KIRBY-NUSS , BY ELECTRONIC SIGNATURE	FD29500088

Cause Of Death (See Instructions And Examples)

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 Additinal Lines If Necessary.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. HYPOXIC ENCEPHALOPATHY	5DAYS
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	B. HYPERTENSION Due to (Or As A Consequence Of):	5YEARS
	C. MESENTERIC ARTERY THROMBOSIS Due to (Or As A Consequence Of):	3DAYS
	D. Due to (Or As A Consequence Of):	

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I: MULTIPLE MEDICAL PROBLEMS

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Finding Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☒ Probably ☐ No ☐ Unknown

32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:	42. Certifier (Check Only One)
YASER ALOBEID , BY ELECTRONIC SIGNATURE	☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
YASER ALOBEID , 8300 BROADWAY # A1, MERRILLVILLE, IN 46410	01058415A	03/05/2011

46. Additional Funeral Service Provider:	47. *Akas:

48. Signature of Local Health Officer:	49. For Registrar Only - Date Filed (Month/Day/Year):
SUSAN W. BEST, VIA ELECTRONIC SIGNATURE	MAR 07 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

FILED
MAR 29 2011
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

951800

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.