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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1784-02 State No. ....

142279

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10 95-06-13-4130-004-000487

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Claudie Strode
2. SEX: Male
3a. TIME OF DEATH: 10:57A M
3b. DATE OF DEATH (Month, Day, Yr): October 2, 2002
4. *SOCIAL SECURITY NUMBER: 310-12-2455
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): July 9, 1921
7. BIRTHPLACE (City and State or Foreign Country): Champaigne, IL
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Barbara McLean
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipefitter
12b. KIND OF BUSINESS/INDUSTRY: Local Union#597
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Munster
13d. STREET AND NUMBER: 7900 Jefferson Ave.
13e. ZIP CODE: 46321
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): 6; College (1-4 or 5+): ---

PARENTS

18. FATHER'S NAME (First, Middle, Last): Wade Stode
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Fish

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Barbara Strode
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7900 Jefferson Ave. Munster, IN 46321
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 7, 2002 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN
22a. EMBALMER'S NAME: John T. Noble
22b. EMBALMER'S LICENSE NO: 9000031
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster, IN 46321

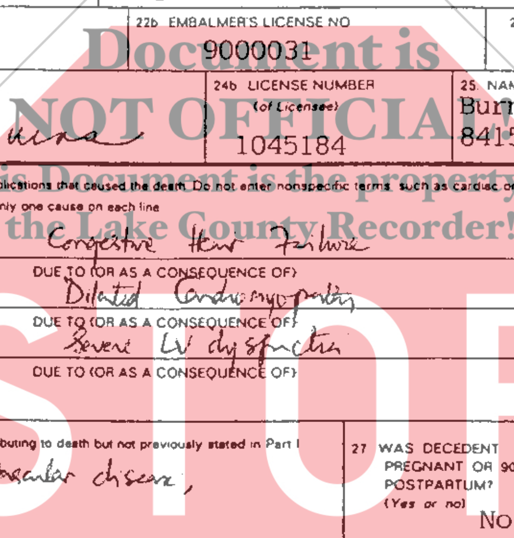
2002 067108

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Dilated Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF)
c. Severe LV dysfunction
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last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PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Renal Failure, Peripheral Vascular disease, atrial Fibrillation

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): --

CERTIFIER

29a. CERTIFIER (Check only one): ☒ 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: x Shridhar Divakarni MD
29c. MEDICAL LICENSE NO: x 01040607
29d. DATE SIGNED (Month, Day, Year): Oct. 2,2002
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S. Divakaruni, M.D. 9116 Columbia Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W. Burt D.O.
32. DATE FILED (Month, Day, Year): October 4, 2002

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

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FILED
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MAY 12 2011
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

SDH06-004 State Form 10110 (R5/1-99)