INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH - RESUBMIT

45-15-05-452-229.000-015

Local No 001427 **EDR No** 000000198185 **State No** 020326

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)
VERONICA GRANT	CASEY	FEMALE	11:00 AM	05/08/2011

5. Social Security Number	6a. Age - Yrs	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)	8. Birthplace (City and State or Foreign Country)
119-24-0295	82					11/04/1928	AUBURN, NY

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): HARTSFIELD CARE CENTER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
MUNSTER, IN, 46321	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
HAROLD M GRANT		SECRETARY	GEORGESON COMP

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

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
11853 107TH PLACE		46373	☒ Yes ☐ No

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

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
PAUL N CASEY	VERONICA M CASEY	RAESLER

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
HAROLD M GRANT	SPOUSE	11853 107TH PLACE, ST. JOHN, IN 46373

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):	SOLAN PRUZIN CREMATORY	SCHERERVILLE, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	SOLAN-PRUZIN FUNERAL SERVICE INC. DBA SOLAN-PRUZIN, 14 KENNEDY AVENUE, SCHERERVILLE, IN 46375	FH10200037

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
DEAN G WAGNER , BY ELECTRONIC SIGNATURE	FD08800057

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. ATHEROSCLEROTIC HEART DISEASE	YEARS
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. Due to (Or As A Consequence Of):	
	C. Due to (Or As A Consequence Of):	
	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

HYPERTENSION, DEMENTIA

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: JAY C L PAIK , BY ELECTRONIC SIGNATURE

42. Certifier (Check Only One) ☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
JAY C L PAIK , 800 MACARTHUR BLVD, #15, MUNSTER, IN 46321	01030770A	05/09/2011

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE

FILED

49. For Registrar Only - Date Filed (Month/Day/Year): MAY 11 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

23-Last: GRANT
45: 5/9/2011 7:30:53 PM
49: 10-MAY-11

MAY 16 2011

052792

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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

11:00 CS
Y/N