

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. 000124

State No. 016088

1. Decedent's Legal Name (First, Middle, Last) <u>GLORIA NAVA</u>				1a. Maiden Last Name (If Female) <u>CASILLAS</u>		2. Sex <u>FEMALE</u>		3. Time Of Death <u>5:49 AM</u>		4. Date Of Death (Month/Day/Year) <u>JUNE 9, 2009</u>			
5. Social Security Number <u>316-44-2349</u>		6a. Age - Yrs <u>65</u>		6b. Under 1 Year Months: _____ Days: _____		6c. Under 1 Month Hours: _____ Minutes: _____		7. Date Of Birth (Month/Day/Year) <u>FEBRUARY 2, 1944</u>		8. Birthplace (City And State Or Foreign Country) <u>EAST CHICAGO, IN</u>			
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		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) <u>ST. CATHERINE'S HOSPITAL</u>													
12. City Or Town, State, And Zip Code <u>EAST CHICAGO</u>						13. County Of Death <u>LAKE</u>			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 <u>ANTHONY NAVA, III</u>				15a. (If Wife) Give Maiden Last Name <u>N/A</u>		16. Decedent's Usual Occupation <u>HOME MAKER</u>			17. Kind Of Business/Industry <u>OWN HOME</u>				
18. Residence - State <u>INDIANA</u>			18a. County <u>LAKE</u>			18b. City Or Town <u>HAMMOND</u>			18c. Street And Number <u>435 VINE STREET</u>		18d. Apt. No. <u>N/A</u>		
18e. Zip Code <u>46384</u>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		19. Decedent's Education <u>12th GRADE</u>		20. Decedent Of Hispanic Origin <u>YES</u>		21. Decedent's Race <u>HISPANIC</u>					
22. Father's Name (First, Middle, Last) <u>JESUS CASILLAS</u>				23. Mother's Name (First, Middle, Last) <u>ALICIA CASILLAS</u>				23a. Mother's Maiden Last Name <u>GARZA</u>					
24. Interment's Name <u>ROBERT NAVA</u>			24a. Relationship To Decedent <u>SON</u>			24b. Mailing Address (Street And Number, City, State, Zip Code) <u>1943 Atchison, Whiting, IN 46394</u>							
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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) <u>RIDGE LAWN CEMETERY</u>			25c. Location - City, Town, And State <u>LAKE COUNTY, INDIANA</u>							
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <u>RIDGE LAWN FUNERAL HOME, 4301 W. RIDGE LAWN, IN 46384</u>											
27b. Signature Of Indiana Funeral Service Licensee: <u>Linda Hanson</u>						27c. License Number (Of Licensee): <u>FD 294500</u>							
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 Arrest</u> B. _____ C. _____ D. _____ Approximate Interval: Onset To Death													
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I													
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input 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 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 type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		34. Date Of Injury (Month/Day/Year)				35. Time Of Injury	
36. Location Of Injury - State		38a. City Or Town		38b. Street & Number		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		38c. Apt. No.		38d. Zip Code <u>052839</u>			
39. Describe How Injury Occurred													
41. Signature, Of Person Certifying Cause Of Death: <u>[Signature]</u>						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 <u>E. Najamuddin, M.D. 3747 45th Ave. Highland, IN 46322 (219) 838-3270</u>						44. License Number <u>#01037869</u>		45. Date Certified <u>6-11-09</u>					
46. Additional Funeral Service Provider:						47. *Akas:							
48. Signature of Local Health Officer: <u>[Signature]</u>						49. For Registrar Only - Date Filed (Month/Day/Year) <u>6/12/09</u>							

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT