refusal.*

Local No. 527-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.........................

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): Dorothy Ann Barrick
2. SEX: Female
3a. TIME OF DEATH: 4:00 PM
3b. DATE OF DEATH (Month, Day, Yr.): February 21, 2005
4. *SOCIAL SECURITY NUMBER: 311-26-2270
5a. AGE - Last Birthday (Years): 76
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): November01,1928
7. BIRTHPLACE (City and State or Foreign Country): Gary Indiana
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
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): 1717 W. 64th
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Daniel W. Barrick Jr.
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: At home
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Merrillville
13d. STREET AND NUMBER: 1717 W. 64th
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
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): 12; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): Roy Hoefle
19. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Nix

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Daniel W. Barrick Jr.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1717 W. 64th, Merrillville, IN 46410
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 24, 2005 Calumet Park Cemetery
21c. LOCATION - City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: James F. Burns
22b. EMBALMER'S LICENSE NO.: FD 01009461
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Burns
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Pulmonary fibrosis — Approximate Interval Between Onset and Death: years
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

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): 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: R. Devanathan
29c. MEDICAL LICENSE NO.:
29d. DATE SIGNED (Month, Day, Year): 2/22/05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print): DR RAIJA DEVANATHAN 1600 S LAKE PARK AVE SUITE 1104, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32. DATE FILED (Month, Day, Year): February 23, 2005

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): February 21, 2005
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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STOP

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

AUG 02 2011

FILED FOR RECORD 2011 AUG -3 PM 12:03 MICHAEL B. BROWN RECORDER

FILED

AUG 03 2011

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

11.00 Cash BB