



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-12-17-453-055-000-038

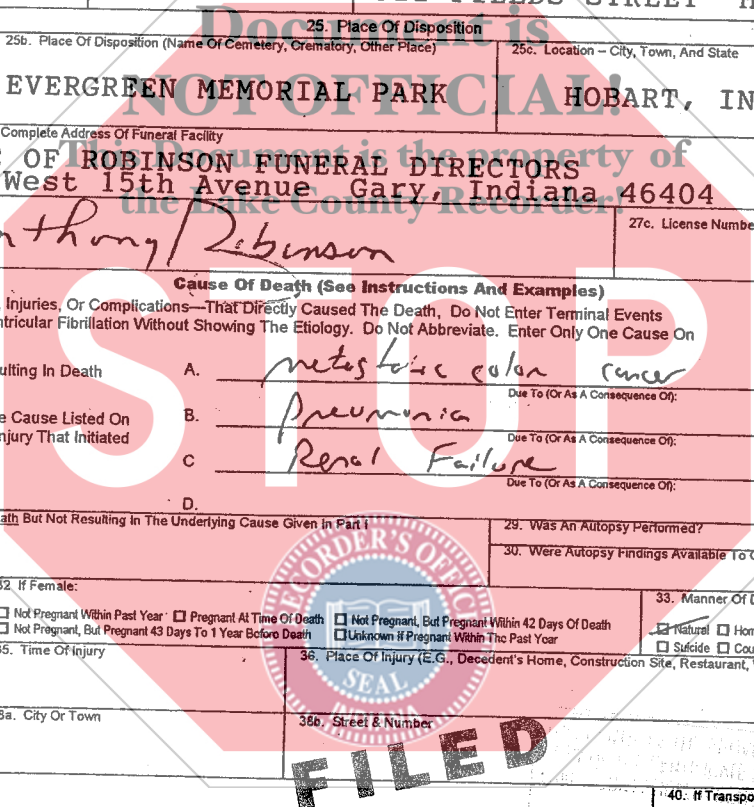
Local No. 620112121
1144-08

Local No.

State No.

1. Decedent's Legal Name (First, Middle, Last) GENEVA C. JAMES				1a. Maiden Last Name (if Female) CARTER		2. Sex FEMALE		3. Time Of Death 2:50pm		4. Date Of Death (Month/Day/Year) MARCH 29, 2008			
5. Social Security Number 620112121		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) NOV. 10, 1933		8. Birthplace (City And State Or Foreign Country) CAPE GIRARDEAU, MISSOURI											
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		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) SAINT MARGARET MERCY HOSPITAL - NORTH													
12. City Or Town, State, And Zip Code HAMMOND, INDIANA						13. County Of Death LAKE			14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name N/A				15a. (If Wife) Give Maiden Last Name N/A				16. Decedent's Usual Occupation NURSE		17. Kind Of Business/Industry HOSPITAL			
18. Residence - State INDIANA				18a. County LAKE				18b. City Or Town MERRILLVILLE		18c. Apt. No.			
18d. Street And Number 2021 West 75th Place				18e. Zip Code 46410				18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
19. Decedent's Education 4 years college				20. Decedent Of Hispanic Origin NO				21. Decedent's Race BLACK					
22. Father's Name (First, Middle, Last) ROBERT CARTER						23. Mother's Name (First, Middle, Last) THELMA FIELDER			23a. Mother's Maiden Last Name TEMPLE				
24. Informant's Name THELMA FIELDER				24a. Relationship To Decedent MOTHER		24b. Mailing Address (Street And Number, City, State, Zip Code) 922 FIELDS STREET HAMMOND, IN 46320							
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) EVERGREEN MEMORIAL PARK				25c. Location - City, Town, And State HOBART, INDIANA					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility HOUSE OF ROBINSON FUNERAL DIRECTORS 1900 West 15th Avenue Gary, Indiana 46404											
27b. Signature Of Indiana Funeral Service Licensee: <i>Paul Anthony Robinson</i>						27c. License Number (Of Licensee): 017284							
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. metastatic colon cancer Due To (Or As A Consequence Of): B. pneumonia Due To (Or As A Consequence Of): C. Renal Failure Due To (Or As A Consequence Of): D. 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													
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 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 type="checkbox"/> No <input checked="" 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 checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <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. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)					
38. Location Of Injury - State				38a. City Or Town				38b. Street & Number		38c. Apt. No.		38d. Zip Code	
39. Describe How Injury Occurred													
41. Signature, Of Person Certifying Cause Of Death: <i>[Signature]</i>						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: G. Scott Beuregard						44. License Number 01052692		45. Date Certified 4/14/08					
46. Additional Funeral Service Provider: HUDSON FUNERAL HOME 8745 S. COMMERCIAL Chicago, IL						47. *Akas: Dorothy Hudson							
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year): April 7, 2008							

CHICAGO TITLE INSURANCE COMPANY



2011 APR 15 9:46 AM
RECORDER
MICHAEL J. JAMMAN
STATE OF INDIANA
FILED FOR RECORD
FHEC 9508007

\$ 11
CT
CA