



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3310-10 Parcel # 45-12-08-127 State No. 010-000-030

1. Decedent's Legal Name (First, Middle, Last) ANASTASIA C. GARCIA				1a. Maiden Last Name (If Female) CHAVEZ		2. Sex F	3. Time Of Death 11:08PM	4. Date Of Death (Month/Day/Year) SEPTEMBER 14, 2010	
5. Social Security Number 314-18-5279		6a. Age Yrs 88	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) January 9, 1922		8. Birthplace (City And State Or Foreign Country) MEXICO
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) METHODIST HOSPITAL									
12. City Or Town, State, And Zip Code MERRILLVILLE, INDIANA 46410					13. County Of Death LAKE		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input 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 OFFICE WORKER		17. Kind Of Business/Industry INSURANCE COMPANY	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MERRILLVILLE					
18c. Street And Number 2403 W. 61ST PLACE						18d. Apt. No.	18e. Zip Code 46410	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education High school graduate or GED completed			20. Decedent Of Hispanic Origin Yes, Mexican/Mexican American/Chicano			21. Decedent's Race White			
22. Father's Name (First, Middle, Last) LONGINOS CHAVEZ					23. Mother's Name (First, Middle, Last) UNAVAILABLE			23a. Mother's Maiden Last Name UNAVAILABLE	
24. Informant's Name JAMES PEREZ		24a. Relationship To Decedent SON		24b. Mailing Address (Street And Number, City, State, Zip Code) 2403 W. 61ST PLACE MERRILLVILLE, INDIANA 46410					
25a. Method Of Disposition: <input type="checkbox"/> Burial <input checked="" 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) KELLY CARROLL CREMATORY			25c. Location - City, Town, And State GARY, INDIANA			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility WHITE FUNERAL HOME & CREMATION SERVICE 921 W. 45TH AVENUE GRIFFITH					27a. Funeral Home License Number: FH10600026		
27b. Signature Of Indiana Funeral Service Licensee <i>Ronald E. White</i>						27c. License Number (Of Licensee) FD08700086			
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 Additional Lines If Necessary.									
Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Sepsis</u> Due To (Or As A Consequence Of):									
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. <u>vesico - euteric fistula</u> 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 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 type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input checked="" 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)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
38. Location Of Injury - State		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: JOSELUIS AGUIRRE 60.5 Valparaiso St Valpo IN 46383						44. License Number 01061624		45. Date Certified 9-17-10	
46. Additional Funeral Service Provider:						47. *AKAS:			
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>						49. For Registrar Only - Date Filed (Month/Day/Year): September 17, 2010			

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the Lake County Recorder!

STOP

FILED
AUG 15 2011
PEGGY HOLING, CLERK
LAKE COUNTY AUDITOR

028259

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

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1/04