



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

539897

Local No 000089

EDR No 000000196664

State No

1. Decedent's Legal Name (First, Middle, Last) ELLEN MARGARET BRAY				1a. Maiden Name (If female) TREWIN		2 Sex FEMALE	3 Time Of Death 06:45 PM	4. Date Of Death (Month/Day/Year) 04/27/2011		
5 Social Security Number 353-26-1149	6a. Age - Yrs 77	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) 10/15/1933		8. Birthplace (City and State or Foreign Country) DES PLAINES, IL		
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) ST CATHERINE HOSPITAL INC				12. City Or Town, State, And Zip Code EAST CHICAGO, IN, 46312		13. County Of Death LAKE		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 checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name JAMES BRAY			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation HOMEMAKER		17. Kind Of Business/Industry OWN HOME			
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town HIGHLAND		18d. Apt. No.		18e. Zip Code 46322	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education ASSOCIATE DEGREE (AA, AS)		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White						
22. Father's Name (First, Middle, Last) ROY TREWIN			23. Mother's Name (First, Middle, Last) LORA TREWIN			23a. Mother's Maiden Last Name GARRETT				
24. Informant's Name JAMES BRAY		24a. Relationship To Decedent HUSBAND		24b. Mailing Address (Street And Number, City, State, Zip Code) 8130 GRACE, HIGHLAND, IN 46322						
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) EVERGREEN CREMATORY		25c. Location - City, Town, And State EVERGREEN PARK, IL						
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322					27a. Funeral Home License Number: FHT0300021			
27b. Signature Of Indiana Funeral Service Licensee: CORNELIUS KUIPER, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee): FD01014511			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. SEPTIC SHOCK 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. METASTATIC COLON CANCER Due to (Or As A Consequence Of): C. _____ Due to (Or As A Consequence Of): D. _____					
28. 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 Finding 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 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			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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			
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: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) 11/2				
41. Signature, Of Person Certifying Cause Of Death: SHELDON RODERICK LEWIS, BY ELECTRONIC SIGNATURE						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: SHELDON RODERICK LEWIS, 3641 RIDGE ROAD, HIGHLAND, IN 46322						44. License Number 01049668A		45. Date Certified 04/29/2011		
46. Additional Funeral Service Provider:						47. *Akas:				
48. Signature of Local Health Officer: PAULA BENCHIK-ABRINKO, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): MAY 02 2011				
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)										
Parcel # 45-07-22-102-042-000-026								028303		

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FILED

AUG 16 2011

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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