



620112337

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Parcel No.: 45-07-32-202-137-000-027

Local No. 4218-09

State No.

CHICAGO TITLE INSURANCE COMPANY

1. Decedent's Legal Name (First, Middle, Last) RUTH L. DEVRIES				1a. Maiden Last Name (If Female) JOHNSON		2. Sex F	3. Time Of Death 9:52 AM	4. Date Of Death (Month/Day/Year) DECEMBER 10, 2009	
5. Social Security Number [REDACTED]	6a. Age Yrs 78	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) October 26, 1931		8. Birthplace (City And State Or Foreign Country) WHITING, INDIANA	
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) COMMUNITY HOSPITAL									
12. City Or Town, State, And Zip Code MUNSTER, INDIANA, 46321					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 type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name MARVIN R. DEVRIES			15a. (If Wife) Give Maiden Last Name N/A		16. Decedent's Usual Occupation HOMEMAKER			17. Kind Of Business/Industry OWN HOME	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MUNSTER			18c. Street And Number 9837 WILDWOOD CIRCLE 1-A		18d. Apt. No. N/A
18e. Zip Code 46321		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 No, not Spanish/Hispanic/Latino		21. Decedent's Race White	
22. Father's Name (First, Middle, Last) VIRGIL JOHNSON			23. Mother's Name (First, Middle, Last) ALBERTUS JOHNSON			23a. Mother's Maiden Last Name JOHNSON			
24. Informant's Name MARVIN R. DEVRIES		24a. Relationship To Decedent HUSBAND		24b. Mailing Address (Street And Number, City, State, Zip Code) 9837 WILDWOOD CIRCLE 1-A MUNSTER, INDIANA 46321					
25. Place Of Disposition CHAPEL LAWN MEMORIAL GARDENS SCHERERVILLE, INDIANA									
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)			25c. Location - City, Town, And State				
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, INDIANA 46322					27a. Funeral Home License Number: EH10300021		
27b. Signature Of Indiana Funeral Service Licensee: <i>C. A. Kuiper</i>						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. CEREBRAL HEMORRHAGE Due To (Or As A Consequence Of): B. HTN Due To (Or As A Consequence Of): C. Hyperlipidemic Due To (Or As A Consequence Of): D. NIDDM 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 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		38a. City Or Town		38b. 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)			
41. Signature Of Person Certifying Cause Of Death: <i>P. Keshvani</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: P. KESHVANI, M.D. 8731 INDIANAPOLIS BLVD. HIGHLAND, INDIANA 46322						44. License Number 01042431		45. Date Certified 12/11/09	
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): December 11, 2009			

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RECORDER'S OFFICE
FILED
AUG 16 2011
IF THIS RECORD IS ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

2011 AUG 16 9:35 AM
LAKE COUNTY RECORDER
STATE OF INDIANA
FILED