



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 002519

EDR No 00000214977

State No 036256

1. Decedent's Legal Name (First, Middle, Last) SANDRA LYNN HOSTETLER				1a. Maiden Name (If female) MOOD		2. Sex FEMALE	3. Time Of Death 05:30 AM	4. Date Of Death (Month/Day/Year) 08/19/2011	
5. Social Security Number 208-36-6007		6a. Age - Yrs 64	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) 05/04/1947		8. Birthplace (City and State or Foreign Country) DOYLESTOWN, PA
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 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 checked="" 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) 246 142ND STREET									
12. City Or Town, State, And Zip Code HAMMOND, IN, 46327					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 BARRY L HOSTETLER				15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation EMT		17. Kind Of Business/Industry MEDICAL SERVICES	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town HAMMOND		18d. Apt. No.	18e. Zip Code 46327	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number 246 142ND STREET		19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) JOHN DONALD MOOD				23. Mother's Name (First, Middle, Last) MARGARET ELIZABETH MOOD		23a. Mother's Maiden Last Name SHILL			
24. Informant's Name BARRY L HOSTETLER			24a. Relationship To Decedent SPOUSE		24b. Mailing Address (Street And Number, City, State, Zip Code) 246 142ND STREET, HAMMOND, IN 46327				
25a. Method Of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) ANATOMY SHARING NETWORK			25c. Location - City, Town, And State INDIANAPOLIS, IN				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility LYNHURST NEIGHBORHOOD FUNERAL HOME, 1202 S. LYNHURST DR., INDIANAPOLIS, IN 46241				27a. Funeral Home License Number: FH10500027			
27b. Signature Of Indiana Funeral Service Licensee: ANTHONY W EDWARDS, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee) FD08700777			
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. NON-SMALL CELL LUNG CANCER WITH METASTASIS TO BONES AND ADRENALS 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. _____ Due to (Or As A Consequence Of) _____ C. _____ Due to (Or As A Consequence Of) _____ D. _____ Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I									
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. Zip Code	
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)			
41. Signature, Of Person Certifying Cause Of Death: LYLE R MUNN, 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: LYLE R MUNN, 1190 NORTH STATE ROAD 49, PORTER, IN 46304						44. License Number 01031582A		45. Date Certified 08/19/2011	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): AUG 22 2011			

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

Parcel # 45-02-25-132-005-000-023

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