INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000903 **EDR No** 000000189450 **State No**

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
JAMES H BODEFELD		MALE	10:45 AM	03/17/2011

5. Social Security Number	6a. Age - Yrs	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)	8. Birthplace (City and State or Foreign Country)
311-36-4996	73					09/10/1937	EAST CHICAGO, IN

9. Ever in U.S. Armed Forces? ☒ Yes ☐ No ☐ Unknown

10. If Death Occurred In A Hospital: ☒ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival

10a. If Death Occurred Somewhere Other Than A Hospital ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number): ST MARGARET MERCY HEALTHCARE CENTERS-DYER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
DYER, IN, 46311	LAKE	☒ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife)Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
JOAN BODEFELD	REEL	SALESMAN	INSURANCE

18. Residence - State	18a. County	18b. City Or Town
INDIANA	LAKE	DYER

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
2626 FOREST PARK DRIVE		46311	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
BACHELOR'S DEGREE (BA, AB, BS)	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
HENRY BODEFELD	MARY BODEFELD	SLOTIS

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
JOAN BODEFELD	WIFE	2626 FOREST PARK DRIVE, DYER, IN 46311

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	BEVERLY CEMETERY	BLUE ISLAND, IL

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	CHAPEL LAWN FUNERAL HOME AND MEMORIAL GARDENS, 8178 S. CLINE AVE., SCHERERVILLE, IN 46375	FH19900051

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
DAVID R PETERSON , BY ELECTRONIC SIGNATURE	FD08601585

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 Additinal Lines If Necessary.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. ISCHEMIC DILATED CARDIOMYOPATHY	5 YEARS
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 Givin In Part I	29. Was An Autopsy Performed?	30. Were Autopsy Finding Available To Complete The Cause Of Death?
HISTORY OF BLADDER/URETHRA CANCER	☐ Yes ☒ No	☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☐ No ☐ Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E... Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:	42. Certifier (Check Only One)
STEPHANIE D. MARSHALL , BY ELECTRONIC SIGNATURE	☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
STEPHANIE D. MARSHALL , 24 JOILET ST ST 401, DYER, IN 46311	02001947A	03/21/2011

46. Additional Funeral Service Provider:	47. *Akas:

48. Signature of Local Health Officer:	49. For Registrar Only - Date Filed (Month/Day/Year):
SUSAN W. BEST, VIA ELECTRONIC SIGNATURE	MAR 22 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

Parcel # 45-10-13-301-012.000-034

028921 11.00 CS

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.