



**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

Local No 002469

EDR No 00000273836

State No 035097

| | | | | | | | | |
|---|----------------------------|---|--|---|---|--|---|---|
| 1. Decedent's Legal Name (First, Middle, Last) BRUCE E AYERS SR | | | 1a. Maiden Name (If female) | | 2. Sex MALE | 3. Time Of Death 06:15 PM | 4. Date Of Death (Month/Day/Year) 08/06/2012 | |
| 5. Social Security Number 314-01-2450 | 6a. Age - Yrs 98 | 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) 08/31/1913 | | 8. Birthplace (City and State or Foreign Country) ROANOKE, IN |
| 9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input 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 MARY MEDICAL CENTER INC | | | | | | | | |
| 12. City Or Town, State, And Zip Code HOBART, IN, 46342 | | | | 13. County Of Death LAKE | | 14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | |
| 15. Surviving Spouse's Name | | | 15a. (If Wife) Give Maiden Last Name | | 16. Decedent's Usual Occupation REALTOR | | 17. Kind Of Business/Industry REAL ESTATE | |
| 18. Residence - State INDIANA | | 18a. County LAKE | | 18b. City Or Town GARY | | | | |
| 18c. Street And Number 550 NORTH MONTGOMERY STREET | | | | | 18d. Apt. No. | 18e. Zip Code 46403 | 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 NOT HISPANIC | | 21. Decedent's Race White | | | | |
| 22. Father's Name (First, Middle, Last) ARTHUR H. AYERS | | | 23. Mother's Name (First, Middle, Last) CARRIE AYERS | | | 23a. Mother's Maiden Last Name HATHAWAY | | |
| 24. Informant's Name GENE AYERS | | 24a. Relationship To Decedent SON | | 24b. Mailing Address (Street And Number, City, State, Zip Code) 9101 LAKE SHORE DRIVE, GARY, IN 46403 | | | | |
| 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) NW INDIANA CREMATION SERVICE | | | 25c. Location - City, Town, And State CROWN POINT, IN | | | |
| 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility BURNS FUNERAL HOME, 701 E. 7TH ST., HOBART, IN 46342 | | | | | 27a. Funeral Home License Number: FH83002380 | |
| 27b. Signature Of Indiana Funeral Service Licensee: JAMES F. BURNS, BY ELECTRONIC SIGNATURE | | | 27c. License Number (Of Licensee): FD01009461 | | | | | |
| 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. | | | | | | | | Approximate Interval: Onset To Death |
| Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>ACUTE EXACERBATION CONGESTIVE HEART FAILURE</u> <small>Due to (Or As A Consequence Of):</small> | | | | | | | | TWO WEEK |
| 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>CHRONIC CONFESTIVE HEART FAILURE</u> <small>Due to (Or As A Consequence Of):</small> | | | | | | | | YEARS |
| C. <u>ARTERIOSCLEROTIC HEART DISEASE</u> <small>Due to (Or As A Consequence Of):</small> | | | | | | | | YEARS |
| D. | | | | | | | | |
| Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I CHRONIC REENAL FAILURE | | | | | 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"/> FSI/MSI/UCI/Other (Specify) <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. 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: DONALD MICHAEL PHILLIPS, 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: DONALD MICHAEL PHILLIPS, 1356 S. LAKE PARK AVENUE, HOBART, IN 46342 | | | | | 44. License Number 01020846A | | 45. Date Certified 08/09/2012 | |
| 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 10 2012 | | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | |