





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH - RESUBMIT

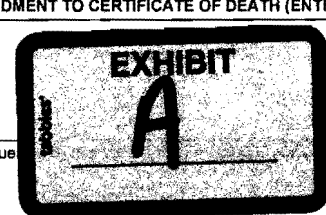
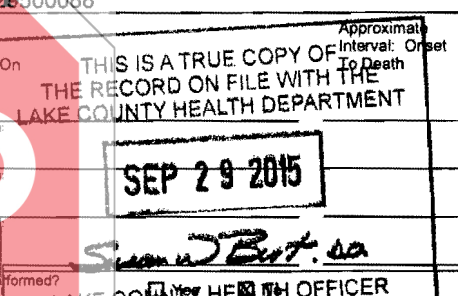
Tracking No. 66118

Local No 003177

EDR No 00000470150

State No 045357

1. Decedent's Legal Name (First, Middle, Last) <b>NANCY CAROL DENHAM</b>				1a. Maiden Name (If female) <b>RUSK</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>03:25 PM</b>	4. Date Of Death (Month/Day/Year) <b>09/19/2015</b>	
5. Social Security Number [REDACTED]	6a. Age - Yrs <b>70</b>	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) <b>08/19/1945</b>		8. Birthplace (City and State or Foreign Country) <b>RENSELAER, IN</b>	
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 checked="" 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) <b>ST ANTHONY HOSPICE-CROWN POINT</b>									
12. City Or Town, State, And Zip Code <b>CROWN POINT, IN, 46307</b>				13. County Of Death <b>LAKE</b>			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 <b>JAMES DENHAM</b>			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation <b>HOMEMAKER</b>		17. Kind Of Business/Industry <b>OWN HOME</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>GRIFFITH</b>		18c. Street And Number <b>4644 RALSTON PLACE</b>	18d. Apt. No.	18e. Zip Code <b>46319</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>			20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>White</b>				
22. Father's Name (First, Middle, Last) <b>HAROLD RUSK</b>			23. Mother's Name (First, Middle, Last) <b>RUBY RUSK</b>			23a. Mother's Maiden Last Name <b>MARTIN</b>			
24. Informant's Name <b>JAMES DENHAM</b>		24a. Relationship To Decedent <b>HUSBAND</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>4644 RALSTON PLACE, GRIFFITH, IN 46319</b>					
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) <b>CHAPEL LAWN MEMORIAL GARDENS</b>			25c. Location - City, Town, And State <b>SCHERERVILLE, IN</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	27. Name And Complete Address Of Funeral Facility <b>CHAPEL LAWN FUNERAL HOME AND MEMORIAL GARDENS, 8178 S. CLINE AVE., SCHERERVILLE, IN 46375</b>					27a. Funeral Home License Number: <b>FH19900051</b>			
27b. Signature Of Indiana Funeral Service Licensee: <b>SHELIA C. KIRBY, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD06500088</b>			
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. <b>SEPSIS</b> 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. _____ C. _____ 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 type="checkbox"/> No			
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. 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: <b>KATHRYN HENKLE MULLIGAN, BY ELECTRONIC SIGNATURE</b>						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: <b>KATHRYN HENKLE MULLIGAN, 919 MAIN STREET, SUITE 102, DYER, IN 46311</b>						44. License Number <b>01052342A</b>		45. Date Certified <b>09/25/2015</b>	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>SEP 29 2015</b>			



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