

2140

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 73035



Local No 004045

EDR No 00000483000

State No 057752

1. Decedent's Legal Name (First, Middle, Last) LOIS ELAINE SELLERS		1a. Maiden Name (if female) BECKMANN		2. Sex FEMALE	3. Time Of Death 19:44	4. Date Of Death (Month/Day/Year) 12/06/2015	
5. Social Security Number	6a. Age - Yrs 70	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) 06/05/1945	
8. Birthplace (City and State or Foreign Country) HAMMOND, IN		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 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, IN 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 ROBERT SELLERS		15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation PURCHASING AGENT		17. Kind Of Business/Industry MEDICAL	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MUNSTER			
19. Street And Number 9619 HAWTHORNE DRIVE		19d. Apt No		19e. Zip Code 46321		19f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education SOME COLLEGE CREDIT, BUT NOT A DEGREE		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) WALDEMAR BECKMANN		23. Mother's Name (First, Middle, Last) LEONA BECKMANN		23a. Mother's Maiden Last Name MELLENTHIN			
24. Informant's Name ROBERT SELLERS		24a. Relationship To Decedent HUSBAND		24b. Mailing Address (Street And Number, City, State, Zip Code) 9619 HAWTHORNE DRIVE, MUNSTER, IN 46321			
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) CONCORDIA CEMETERY		25c. Location - City, Town, And State HAMMOND, IN			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility ANTHONY & DZIADOWICZ FUNERAL HOME, INC., MUNSTER, 9445 CALUMET AVE, MUNSTER, IN 46321				27a. Funeral Home License Number FH83002916	
27b. Signature Of Indiana Funeral Service Licensee KYLE J. KUTLIK, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee) FD3000089		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 A Line. Add Additional Lines If Necessary.			
Immediate Cause (Final Disease Or Condition Resulting In Death) A. PNEUMONIA		B. PULMONARY FIBROSIS		C.		D.	
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		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 checked="" type="checkbox"/> No		Approximate Interval: Onset To Death ONSET TO DEATH	
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I PULMONARY FIBROSIS		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 checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 45 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 45 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. Location Of Injury - State		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" 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: RICHARD L. GOOD, BY ELECTRONIC SIGNATURE			
42. Certifier (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		44. License Number 01027057A		45. Date Certified 12/09/2015			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death RICHARD L. GOOD, 9307 CALUMET AVENUE SUITE 2, MUNSTER, IN 46321		46. Additional Funeral Service Provider: ADAMS FUNERAL HOME		47. *Abas			
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE		49. For Registrar Only - Date Filed (Month/Day/Year): DEC 10 2015					
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)							

