

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

# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

18  
State No. **045538**  
E000E W75

Local No. #03-0837

RESUBMIT THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>(b)(3):CPSA Section 25(c)</b>		2 SEX Female	3a TIME OF DEATH 2:10 P M	3b DATE OF DEATH (Month, Day, Yr) November 19, 2003
4 SOCIAL SECURITY NUMBER <b>(b)(3):CPSA</b>	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months: 3 Days: 3	5c UNDER 1 DAY Hours: Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>(b)(3):CPSA Section 25(c)</b>
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		

DECEDENT

9b FACILITY NAME (If not institution, give street and number) <b>(b)(6)</b>		9c CITY, TOWN, OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Never Married	11 SURVIVING SPOUSE (If wife, give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) N/A	12b KIND OF BUSINESS/INDUSTRY N/A

PARENTS

13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER <b>(b)(6)</b>
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
18 FATHER'S NAME (First, Middle, Last) <b>(b)(6)</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>(b)(6)</b>	

INFORMANT

20a INFORMANT'S NAME (Type/Print) <b>(b)(6)</b>	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>(b)(6)</b>	20c Relationship Mother
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DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>(b)(6)</b> November 25, 2003	21c LOCATION—City or Town, State
22a EMBALMER'S NAME <b>(b)(6)</b>	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

CAUSE OF DEATH

24a SIGNATURE OF FUNERAL DIRECTOR <b>(b)(6)</b>	24b LICENSE NUMBER (of Licensee) <b>(b)(6)</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>(b)(6)</b>
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26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death	IMMEDIATE CAUSE (Final disease or condition resulting in death) Positional asphyxia a. DUE TO (OR AS A CONSEQUENCE OF)	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

CERTIFIER

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a WAS AN AUTOPSY PERFORMED? (Yes or no) Yes	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes
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29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input checked="" type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place and due to the cause(s) as stated. Chief Deputy <input checked="" type="checkbox"/> CORONER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place and due to the cause(s) and manner as stated	29b MEDICAL LICENSE NO. N/A	29c DATE SIGNED (Month, Day, Year) February 24, 2004
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HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE <b>(b)(6)</b>	32 DATE FILED (Month, Day, Year) MAR 05 2004
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33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	34a DATE OF INJURY (Month, Day, Year) Nov 19, 2003	34b TIME OF INJURY Unknown	34c INJURY AT WORK? (Yes or no) No	34d DESCRIBE HOW INJURY OCCURRED Decedent lying prone in a crib with a full size pillow and bumper pads
	34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Residence	34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>(b)(6)</b>		

34g DATE PRONOUNCED DEAD (Month, Day, Year) November 19, 2003	34h MOTOR VEHICLE ACCIDENT? (Yes or no. If yes, specify driver, passenger, pedestrian, etc.) No
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