TATE: The Social Security # is y this state agency in order to y responsibility. Disclosure is will be no penalty for refusal.
5.14.04

INDIANA STATE DEPARTMENT OF HEALTH

014121

CERTIFICATE OF DEATH

State No. .....

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

1. DECEASED—NAME (First, Middle, Last): JEAN F. CHIRILA		2. SEX: Female	3a. TIME OF DEATH: 12:03 PM	3b. DATE OF DEATH (Month, Day, Yr.): March 12, 2004
5a. AGE—Last Birthday (Years): 70	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr.): July 25, 1933	7. BIRTHPLACE (City and State or Foreign Country): Gary Indiana
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence	
9b. FACILITY NAME (If not institution, give street and number): 3115 West Old Ridge Road		9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart		9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed	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): Secretary		12b. KIND OF BUSINESS/INDUSTRY: Steel
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Hobart		13d. STREET AND NUMBER: 3115 West Old Ridge Road
13e. ZIP CODE: 46342	13f. INSIDE CITY LIMITS ☐ No ☒ Yes; 13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify): White
				17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):
18. FATHER'S NAME (First, Middle, Last): Harry Calfas			19. MOTHER'S NAME (First, Middle, Maiden Surname): Eugenia Rektarski	
20a. INFORMANT'S NAME (Type/Print): Maxine Michaels	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1272 Vanderburgh Street, Valparaiso, IN 46385			20c. Relationship: Cousin
21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Mar 16, 2004 Graceland Cemetery		21c. LOCATION—City or Town, State: Valparaiso IN	
22a. EMBALMER'S NAME: James J. Krause	22b. EMBALMER'S LICENSE NO: FD01006463	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause	24b. LICENSE NUMBER (of Licensee): FD01006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488		

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)	a. Lung Cancer	years
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)	

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): No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

29a. CERTIFIER (Check only one)
- ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
- ☐ 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.
- ☐ 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. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
R. Devanathan	01040141	3/16/04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Raja Devanathan MD 1600 S. Lake Park Ave,Ste 1104, Hobart, IN 46342

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Susan D Bay D.O.	March 17, 2004

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				
	34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

SDH06-004 State Form 10110 (R5/1-99)