



# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 000 828

State No. 035680

1. Decedent's Legal Name (First, Middle, Last) <b>ALICE IRENE BENDER</b>			1a. Maiden Last Name (If Female) <b>HOWE</b>		2. Sex <b>F</b>	3. Time Of Death <b>1:05 A.M.</b>	4. Date Of Death (Month/Day/Year) <b>NOVEMBER 14, 2009</b>	
5. Social Security Number <b>85</b>	6a. Age - Yrs <b>85</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>November 15, 1923</b>		8. Birthplace (City And State Or Foreign Country) <b>BLOOMINGTON, INDIANA</b>
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		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 type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input checked="" type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street And Number) <b>STERLING HOUSE</b>								
12. City Or Town, State, And Zip Code <b>BLOOMINGTON, INDIANA 47401</b>					13. County Of Death <b>MONROE</b>		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 <b>N/A</b>			15a. (If Wife) Give Maiden Last Name <b>N/A</b>		16. Decedent's Usual Occupation <b>OPHTHALMIC ASSISTANT</b>		17. Kind Of Business/Industry <b>EYE CARE</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>MONROE</b>		18b. City Or Town <b>BLOOMINGTON</b>				
18c. Street And Number <b>3876 REGENTS CIRCLE</b>					18d. Apt. No.	18e. Zip Code <b>47401</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>No, not Spanish/Hispanic/Latino</b>		21. Decedent's Race <b>White</b>			
22. Father's Name (First, Middle, Last) <b>FRED H. HOWE</b>				23. Mother's Name (First, Middle, Last) <b>THENA ESTHER HOWE</b>			23a. Mother's Maiden Last Name <b>ROBERTS</b>	
24. Informant's Name <b>IRENE REEDY</b>			24a. Relationship To Decedent <b>DAUGHTER</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>3876 REGENTS CIRCLE; BLOOMINGTON, IN 47401</b>			
25. Place Of Disposition								
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>ROSE HILL CEMETERY</b>			25c. Location - City, Town, And State <b>BLOOMINGTON, INDIANA</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>DAY FUNERAL HOME 4150 E. THIRD ST. BLOOMINGTON, IN 47401</b>					27a. Funeral Home License Number. <b>FH10200030</b>	
27b. Signature Of Indiana Funeral Service Licensee <i>Amy C. Arvold</i>					27c. License Number (Of Licensee) <b>FDO1016513</b>			
<b>Cause Of Death (See Instructions And Examples)</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. <u>Uterine Cancer</u> Due To (Or As A Consequence Of) <u>3yrs</u> 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. _____ Due To (Or As A Consequence Of) _____ C. _____ Due To (Or As A Consequence Of) _____ D. _____								Approximate Interval: Onset To Death <b>3yrs</b>
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 checked="" type="checkbox"/> No		30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input 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"/> 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 <i>Brad Bombardieri</i>					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>Brad Bombardieri, 550 Landmark Ave Blgtn IN 47401</b>						44. License Number <b>1037706</b>	45. Date Certified <b>November 17, 2009</b> <i>11/17/09</i>	
46. Additional Funeral Service Provider						47. *Atas		
48. Signature of Local Health Officer <i>Thomas W. Morgan</i>					49. For Registrar Only - Date Filed (Month/Day/Year) <b>NOV 19 2009</b>			