

2971

07-19-95A11:30 RCVD

18678

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1 DECEASED—NAME (First, Middle, Last) Irma L. De Graff				2 SEX Female		3a TIME OF DEATH 3:15P		3b DATE OF DEATH (Month, Day, Year) July 7, 1995	
4 SOCIAL SECURITY NUMBER 313-14-3947		5a AGE—Last Birthday (Year) 73		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) April 3, 1922	
7 BIRTHPLACE (City and State or Foreign Country) Mishawaka, Indiana		8a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)							
9b FACILITY NAME (If not institution, give street and number) Fountainview Place				9c CITY, TOWN OR LOCATION OF DEATH Mishawaka				9d COUNTY OF DEATH St. Joseph	
10 MARITAL STATUS (Specify) Widowed		11 SURVIVING SPOUSE (If wife, give maiden name) none		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sew Shoes				12b KIND OF BUSINESS/INDUSTRY UniRoyal, Inc.	
13a RESIDENCE—STATE Indiana		13b COUNTY St. Joseph		13c CITY, TOWN, OR LOCATION Mishawaka				13d STREET AND NUMBER 609 Tanglewood Lane	
13e ZIP CODE 46545		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16 RACE—American Indian, Black, White, etc. (Specify) White	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 0							
18 FATHER'S NAME (First, Middle, Last) Otto F. Detert				19 MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Mary Mann					
20a INFORMANT'S NAME (Type/Print) Marlene Finnigan				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Longhorn Dr., Mishawaka, Indiana 46544				20c Relationship Daughter	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Entombment <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) July 11, 1995, Riverview Crematory				21c LOCATION—City or Town, State South Bend, Indiana	
22a EMBALMER'S NAME N/A				22b EMBALMER'S LICENSE NO. N/A				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>M. Wayne Tinsley</i>				24b LICENSE NUMBER (of License) FDO1017064				25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Thallermer-Coethals, FH83004667, 503 W. 3rd St., Mishawaka, IN 46544	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF) Chronic Obstructive Lung Disease DUE TO (OR AS A CONSEQUENCE OF) CHRONIC OBSTRUCTIVE LUNG DISEASE Approximate Interval Between Onset and Death 3-4 days years									
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I									
27 WAS DECEASED 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) <input checked="" 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 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 <input 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) as stated									
29b SIGNATURE AND TITLE OF CERTIFIER <i>George Plain, M.D.</i>				29c MEDICAL LICENSE NO. 27758				29d DATE SIGNED (Month, Day, Year) JULY 11, 1995	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Craig B. Elliott, M.D., 720 Cedar, South Bend, Indiana 46617									
31 HEALTH OFFICER'S SIGNATURE <i>George Plain, M.D.</i>								32 DATE FILED (Month, Day, Year) JULY 11, 1995	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)		34d DESCRIBE HOW INJURY OCCURRED	
		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.					

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Mountain Title Co the 19th day of July A.D., 19 95 at 11:30 o'clock A M., and duly recorded in Vol. M95 of Deeds on Page 18678

FEE \$10.00 RETURN: See back

Bernetha G. Lisch, County Clerk

By *Loretta Hickey*

This is a true and correct copy of the original document as it appears on Record No. 46545 in the St. Joseph County Health Department