ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 99-042 State No. 012020

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (First, Middle, Last): MARGUERITE KOLLING
2. SEX: FEMALE
3a. TIME OF DEATH: 4:30A M
3b. DATE OF DEATH (Month, Day, Yr.): March 9, 1999
4. SOCIAL SECURITY NUMBER: 317 20 9061
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): September 2, 1911
7. BIRTHPLACE (City and State or Foreign Country): Schererville, 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 XXX Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): OUR LADY OF HOLY CROSS
9c. CITY, TOWN, OR LOCATION OF DEATH: SAN PIERRE
9d. COUNTY OF DEATH: STARKE
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
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Starke
13c. CITY, TOWN, OR LOCATION: San Pierre
13d. STREET AND NUMBER: 7520 S. State Road 421
13e. ZIP CODE: 46374
13f. INSIDE CITY LIMITS: XX No ☐ Yes
13g. ON A FARM?: ☐ XXXXXX
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: X 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): ; College (1-4 or 5+): 1 Year

PARENTS

18. FATHER'S NAME (First, Middle, Last): Michael Kolling
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rova Titus

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Betty Tragessor
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711-173rd St. Hammond, IN 46324
20c. Relationship: Friend

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 11, 1999 St. Michael Cemetery
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Dean G. Wagner
22b. EMBALMER'S LICENSE NO: 8800057
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean G. Wagner
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Solan Funeral Home FH 83002893 7109 Calumet Ave. Hammond, IN 46324

CAUSE OF DEATH

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. PNEUMONIA
b. DUE TO (OR AS A CONSEQUENCE OF)
c. DUE TO (OR AS A CONSEQUENCE OF)
d. DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: CONGESTIVE HEART FAILURE SCHIZOPHRENIA

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): N/A

CERTIFIER

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: A Damodaran, MD
29c. MEDICAL LICENSE NO.: 01028450
29d. DATE SIGNED (Month, Day, Year): 3.17.99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.N. Damodaran MD 1002 Edge wood Drive, Knox, IN 46534

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Walter Batz MD
32. DATE FILED (Month, Day, Year): March 17, 1999

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE WITH THE INDIANA STATE DEPARTMENT OF HEALTH.

JAN 10 2011

CERTIFICATE
State Form 26217 (R2 / 7-09)

311138

Not valid unless machine signed with multi-colored ribbon.
It is unlawful to reproduce this record.