



# UNOFFICIAL COPY

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## Legal Description

of premises commonly known as 17528 Wright Street Lansing, IL 60438

Lot 5 in Dykstra's Wright Street Third Addition, A subdivision of the West ½ of the Southwest ¼ of the Northeast ¼ of the Southwest ¼ of Section 22, Township 36 North, Range 15, East of the Third Principal Meridian, in Cook County, Illinois.

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracking No.

22483



Local No 002058

EDR No 000000392438

State No 029416

1. Decedent's Legal Name (First, Middle, Last) <b>BETTY J HOUSE</b>				1a. Maiden Name (If female) <b>SHEARER</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>12:27 PM</b>	4. Date Of Death (Month/Day/Year) <b>06/21/2014</b>	
5. Social Security Number <b>337-44-4984</b>	6a. Age - Yrs <b>63</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>05/30/1951</b>		8. Birthplace (City and State or Foreign Country) <b>CHICAGO, IL</b>	
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" 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 type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street and Number) <b>COMMUNITY HOSPITAL</b>									
12. City Or Town, State, And Zip Code <b>MUNSTER, IN, 46321</b>				13. County Of Death <b>LAKE</b>			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>STEVE HOUSE</b>			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation <b>INSURANCE SALES</b>		17. Kind Of Business/Industry <b>INSURANCE</b>	
18. Residence - State <b>ILLINOIS</b>		18a. County <b>COOK</b>		18b. City Or Town <b>LANSING</b>		18d. Apt. No.	18e. Zip Code <b>60438</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number <b>17528 WRIGHT STREET</b>		19. Decedent's Education <b>ASSOCIATE DEGREE (AA, AS)</b>			20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>Black or African American</b>		
22. Father's Name (First, Middle, Last) <b>ROOSEVELT SHEARER</b>				23. Mother's Name (First, Middle, Last) <b>GENEVIEVE SHEARER</b>		23a. Mother's Maiden Last Name <b>ROBINSON</b>			
24. Informant's Name <b>STEVE HOUSE</b>		24a. Relationship To Decedent <b>HUSBAND</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>17528 WRIGHT STREET, LANSING, IL 60438</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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>FOREST CREMATORY</b>			25c. Location - City, Town, And State <b>HOMEWOOD, IL</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>BURNS-KISH FUNERAL HOME INC-HAMMOND, 5840 HOHMAN AVE, HAMMOND, IN 46321</b>					27a. Funeral Home License Number: <b>FH83002819</b>		
27b. Signature Of Indiana Funeral Service Licensee: <b>BRIAN T. BURNS, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>ED08691763</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>CARDIAC DYSRHYTHMIA</u> Due to (Or As A Consequence Of) _____									
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. _____ Due to (Or As A Consequence Of) _____									
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I <b>CARDIOMYOPATHY</b>						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval: Onset To Death <b>UNKNOWN</b>	
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No						THIS IS A TRUE COPY OF RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT <b>JUL 03 2014</b> <i>Susan W Best, MD</i> LAKE COUNTY HEALTH OFFICER			
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input checked="" 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: <b>ALAN CAM SENH, BY ELECTRONIC SIGNATURE</b>						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>ALAN CAM SENH, 901 MACARTHUR BLVD., MUNSTER, IN 46321</b>						44. License Number <b>01070218A</b>		45. Date Certified <b>07/02/2014</b>	
46. Additional Funeral Service Provider: <b>FOR CREMATION SOCIETY OF IL SIGNATURE ONLY</b>						47. Date <b>JUL 03 2014</b>			
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year) <b>JUL 03 2014</b>			
<b>AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)</b>									