

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

022500

Local No.

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Theresa Ann Nichols Rideout		2 SEX F	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Year) August 12, 2002
5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) 2-22-58	7 BIRTHPLACE (City and State or Foreign Country) Connecticut
8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence <input type="checkbox"/>		
9b FACILITY NAME (If not institution, give street and number)		9c CITY, TOWN OR LOCATION OF DEATH Warrick	9d COUNTY OF DEATH Warrick	
10 MARITAL STATUS (Specify) Divorced	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Waitress	12b KIND OF BUSINESS/INDUSTRY	
13a RESIDENCE—STATE IN	13b COUNTY Warrick	13c CITY, TOWN OR LOCATION Chandler	13d STREET AND NUMBER 6833 Maple Heights	
13a ZIP CODE	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)
13g ON A FARM? <input type="checkbox"/> No <input type="checkbox"/> Yes	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+)			
18 FATHER'S NAME (First, Middle, Last) William R. Nichols		19 MOTHER'S NAME (First, Middle, Maiden Surname) Eust V. Wiggam		
20a INFORMANT'S NAME (Type/Print)		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <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) N/A		21c LOCATION—City or Town, State N/A
22a EMBALMER'S NAME N/A		22b EMBALMER'S LICENSE NO. N/A	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR N/A		24b LICENSE NUMBER (of Licensee) N/A	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME N/A	
26 PART I Enter the disease, 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) a. Court Order #87D01-0206-EU-015 DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Presumed dead - last seen 9-2-94				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		28a WAS AN AUTOPSY PERFORMED? (Yes or no) N/A	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A	
29a CERTIFIER (Check only one) <input 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) and manner as stated.		29b SIGNATURE AND TITLE OF CERTIFIER N/A	29c MEDICAL LICENSE NO. N/A	29d DATE SIGNED (Month, Day, Year) N/A
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) N/A		31 HEALTH OFFICER'S SIGNATURE /State Registrar		
32 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 checked="" type="checkbox"/> Homicide Probable		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)		32 DATE FILED (Month, Day, Year)		
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