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Key # 46-291-21
288 F. 21 Pl. 10
Prose add. Miller

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY DEPT. OF HEALTH

EMBALMER'S NAME Wallace Health Dept.
FUNERAL DIRECTOR'S NAME W. J. Head
SIGNATURE [Signature]

FUNERAL HOME No. 490

FUNERAL DIRECTOR'S LICENSE No. 2381

FUNERAL DIRECTOR'S LICENSE No. 26

776095
Local No. 1301-84

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State No. 885 Blue Suite Mrs. 889

DECEASED NAME 1 Dorothy Schulman		SEX 2 Female	DATE OF DEATH (MONTH DAY YEAR) 3 July 9, 1984
RACE 4 White	AGE - Last Birthday 5a 71	DATE OF BIRTH (MO DAY YEAR) 6 7/7/13	COUNTY OF DEATH 7a Lake
CITY, TOWN OR LOCATION OF DEATH 7b Merrillville		HOSPITAL OR OTHER INSTITUTION (Name, Street and number) 7c Merrillville Care Center	IF HOSP OR INST (Specify type and number) 7d Inpatient
STATE OF BIRTH (or born in U.S.A.) 8 Illinois	CITIZEN OF WHAT COUNTRY 9 U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 10 Married	SURVIVING SPOUSE (Name) 11 Leonard
SOCIAL SECURITY NUMBER 13 306-34-1555		USUAL OCCUPATION (Specify kind of work done during most of life) 14a Homemaker	KIND OF BUSINESS OR INDUSTRY 14b
RESIDENCE - STATE 15a Indiana	COUNTY 15b Lake	CITY, TOWN OR LOCATION 15c Griffith	STREET AND NUMBER 15d 1733 Mansard Blvd.
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		IS RESIDENCE ON A FARM? 15e YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FATHER - NAME (FIRST MIDDLE LAST) 16 Benjamin Kaplan		MOTHER - MAIDEN NAME (FIRST MIDDLE LAST) 17 Hollie Bartelstein	
INFORMANT - NAME (Type or print) 18a Leonard/Husband	RELATIONSHIP 18b	MAILING ADDRESS (STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP) 18c 1733 Mansard Blvd. Griffith Indiana 46321	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a Burial	CEMETERY OR CREMATORY - FUNERAL HOME 19b Beth El Cemetery	LOCATION (CITY OR TOWN STATE) 19c Portage Indiana	
DATE (MONTH DAY YEAR) 20a July 11, 1984	FUNERAL HOME (NAME AND ADDRESS) (STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP) 20b Burns-Kish F.H. 8415 Calumet Ave. Munster In.		
To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 21a (Signature) Michael H. Stern, M.D.		DATE SIGNED (MO DAY YEAR) 21b July 11, 1984	HOUR OF DEATH 21c 10:25 P.M.
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d Dr. Stern			
MAILING ADDRESS - PHYSICIAN 21e 601 W. 61st St. Merrillville, Ind 46410			
HEALTH OFFICER (Name) 22a Charles Johnson, M.D.			DATE RECEIVED BY LOCAL HEALTH OFFICER 22b 7-12-84
IMMEDIATE CAUSE (ENTER UNDER ONE CAUSE PER LINE FOR (a) AND (b)) PART (a) PNEUMONIA		Interval between onset and death	
(b)		Interval between onset and death	
(c)		Interval between onset and death	
OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in PART 21a) PART II ALZHEIMER'S DISEASE		AUDITOR LAKE COUNTY 24	

PARENTS
D.O.B.
DISPOSITION
LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA
DEPT. OF HEALTH
WILLIAM B. REORDER
2025
NOV 15 1984

FILED
OCT 15 1984

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