Local No. 503 993290

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
JUN 0 8 1988 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: FIRST I. MIDDLE Irene LAST Erickson
2 SEX: Female
3 DATE OF DEATH (Mo. Day Yr): June 6, 1988
4 SOCIAL SECURITY NUMBER: 514-01-8160
5a AGE—Last Birthday (Years): 73
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Month Day Year): Nov. 6, 1914
7 BIRTHPLACE (City and State or Foreign Country): Sharon, Kentucky
8 YEAR LAST SERVED IN U.S. ARMED FORCES?: none
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): married
11 SURVIVING SPOUSE (If wife give maiden name): Dell Erickson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Avon Rep. (10) yrs.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 641 Sibley Blvd.
13e INSIDE CITY LIMITS? (Yes or no): yes
13f FARM: no
13g ZIP CODE: 46320
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.): NO
15 RACE—American Indian, Black, White, etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): secondary; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): Thoams Baker
18 MOTHER'S NAME (First, Middle, Maiden Surname): Anna Smith

INFORMANT

19a INFORMANT'S NAME (Type/Print): Mr. Dell B. Erickson
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 641 Sibley Blvd. Hammodn, Indiana 46320
19c Relationship: Husband

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 9, 1988 Chapel Lawn Memorial Gardens
20c LOCATION—City or Town, State: Schererville, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b LICENSE NUMBER (of Licensee): FDE1013507
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FDH3002801, 7042 Kennedy Avenue, Hammond, Indiana 46323

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.
23a To the best of my knowledge, death occurred at the time, date and place stated. Signature and Title
23b LICENSE NUMBER
23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 6:15 a.M
25 DATE PRONOUNCED DEAD (Month, Day, Year): June 6, 1988
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): no

CAUSE OF DEATH

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardiorespiratory arrest (Cardiorespiratory arrest)
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic congestive heart failure (Chronic congestive heart failure)
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Myeloproliferative disease (myelofibrosis) (Myeloproliferative disease(myelofibrosis)); Massive ascites (Massive ascites)
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

CERTIFIER

29a CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) and manner as stated
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated
29b SIGNATURE AND TITLE OF CERTIFIER: [signature] James B. Walsh
29c LICENSE NUMBER: 27487
29d DATE SIGNED (Month, Day, Year): June 8, 1988
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J.B. Walsh, M.D. 5500 Hohman Avenue, Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] Franklin ... M.D.
32 DATE FILED (Month, Day, Year): JUN 0 8 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED: 1242
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)

FILED AUG 19 1988 — [signature] AUDITOR LAKE COUNTY

FILED FOR RECORD AUG 19 — LILLIAN A. BLASTICK, RECORDER, LAKE COUNTY, CROWN POINT, INDIANA 46307

Handwritten margin notes: Key # 34-132-22, Addition L. 20 Bl 2; L. E. Hohmans

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