

997334

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.

AUG 24 1988

Date Issued Hammond Health Commissioner

Local No.

717

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

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

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

| | | | | | | | |
|--|--|--|--|---|---|--|--|
| 1 DECEASED—NAME FIRST MIDDLE LAST Mary V. Hohenberger | | | | 2 SEX Female | 3 DATE OF DEATH (Mo. Day, Yr.) August 21, 1988 | | |
| 4 SOCIAL SECURITY NUMBER 310-22-5297 | | 5a AGE—Last Birthday (Years) 62 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Month Day, Year) May 20, 1926 | | |
| 8 YEAR LAST SERVED IN U.S. ARMED FORCES? None | | 9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> 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) Richard Hohenberger | | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker | | | |
| 12b KIND OF BUSINESS/INDUSTRY Own Home | | 13a RESIDENCE—STATE Indiana | | 13b COUNTY Lake | | | |
| 13c CITY, TOWN, OR LOCATION Hammond | | 13d STREET AND NUMBER 48 Mason Street | | 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.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| 15 RACE—American Indian, Black, White, etc. (Specify) White | | 16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 17 FATHER'S NAME (First, Middle, Last) Andrew Pilzer | | | |
| 18 MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Kintzele | | 19a INFORMANT'S NAME (Type/Print) Richard Hohenberger | | 19b MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Mason St. Hammond, IN 46320 | | | |
| 19c Relationship Husband | | 20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 24, 1988 St. Joseph | | | |
| 20c LOCATION—City or Town, State Hammond, Indiana | | 21a SIGNATURE OF FUNERAL DIRECTOR Thomas J. Burns | | 21b LICENSE NUMBER (of Licensee) 1045841 | | | |
| 22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Homes, Inc. Hammond, Indiana 3002819 | | 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) | | 24 TIME OF DEATH 4:08 p. M | | 25 DATE PRONOUNCED DEAD (Month, Day, Year) August 21, 1988 | | | |
| 26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) NO | | 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Septic Shock (Septic shock) DUE TO (OR AS A CONSEQUENCE OF) Cellulitis left leg (Cellulitis left leg) Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Pulmonary Fibrosis (Pulmonary fibrosis) DUE TO (OR AS A CONSEQUENCE OF) | | 28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO | | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF DEATH CERTIFICATE? SEP 14 1988 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23b) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> 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. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated. | | 29b SIGNATURE AND TITLE OF CERTIFIER John W. George M.D. AUDITOR LAKE COUNTY | | | |
| 29c LICENSE NUMBER 31470 | | 29d DATE SIGNED (Month, Day, Year) August 22, 1988 | | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) J. George, M.D. 7905 Calumet Avenue, Munster, Indiana 46321 | | | |
| 31 HEALTH OFFICER'S SIGNATURE Franklin D. ... | | 32 DATE FILED (Month, Day, Year) AUG 24 1988 | | 33 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 type="checkbox"/> Homicide | | | |
| 34a DATE OF INJURY (Month, Day, Year) | | 34b TIME OF INJURY | | 34c BURN—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) | | | |

Key # 34-143-44, 45, 46 Homewood, add of 57, 58, 59 & W3 p 260 Bl. 4

LILLIAN A. BLASTICK
REORDER, LAKE COUNTY
CROWN POINT, INDIANA
FILED
SEP 14 1988
LAKE COUNTY, INDIANA

for