083917 INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 3-10-90 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
JUNE G. PANGBURN	Female	10:31P M	January 30, 1990

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr)	7. BIRTHPLACE (City and State or Foreign Country)
307-42-6094	49			JAN 15, 1941	MANCHESTER, TENNESSEE

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)
No	N/A	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	LAKE

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	SANFORD J. PANGBURN	VICE PRESIDENT NURSING	ST. MARY MEDICAL CENTER

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	HOBART	626 LIBERTY COURT

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE		4

PARENTS

18. FATHER'S NAME (First Middle Last)	19. MOTHER'S NAME (First Middle Maiden Surname)
HERBERT LAFAVRE	CHESTEL BUSH

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
SANFORD J. PANGBURN	626 LIBERTY COURT, HOBART, IN 46342	Husband

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	FEB 2, 1990 GRACELAND CEMETERY	VALPARAISO, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FD01004194	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature] Gerald Rees	FD01041083	FDH3003069 REES FUNERAL HOME 600 W. OLD RIDGE RD. HOBART, IN 46342

THIS IS TRUE AND CORRECT COPY ... WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

26. PART I. Enter the diseases, 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): carcinoma of ovary — 6 mo plus

DUE TO (OR AS A CONSEQUENCE OF)

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Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

FILED FEB 9, 1990

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

[signature] Anna N. Anton AUDITOR LAKE COUNTY

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	N/A

CERTIFIER

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.

☐ 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.

☐ 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month Day Year)
[signature] M.D.	01020846	2/2/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DONALD PHILLIPS M.D., 1356 S. LAKE PARK AVE., HOBART, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
[signature]	FEB 2, 90

CORONER USE ONLY

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

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)

34g. DATE PRONOUNCED DEAD (Month Day Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Key# 21-33-28 to 30 New Chicago 3rd Add. L.27 to 30 BL.12

Key# 17-208-2 Wilson's Circle

421