094246

Local No. 703-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Shirley R. Asboth
2. SEX: Female
3a. TIME OF DEATH: 7:05 P M
3b. DATE OF DEATH (Month, Day, Yr.): March 23, 1990
4. SOCIAL SECURITY NUMBER: 388-18-4681
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): Mar. 1, 1920
7. BIRTHPLACE (City and State or Foreign Country): Kenosha, Wisconsin
8a. WAS DECEDENT A U.S. VETERAN?: N/A
8b. YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 3245 Glenwood
9c. CITY, TOWN, OR LOCATION OF DEATH: Highland
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Lewis Asboth
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: Highland
13d. STREET AND NUMBER: 3245 Glenwood
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS: ☐ No X Yes
13g. ON A FARM?: X No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: X No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Walter Petersen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Celestia Bray

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lewis Asboth
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3245 Glenwood Highland, Indiana 46322
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: X Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 28, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: David Peterson
22b. EMBALMER'S LICENSE NO.: FDO 8601585
23. WAS DEATH REPORTED TO CORONER?: X No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardio Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Ven[illegible] Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
c. Multiple Myeloma
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
WAS AN AUTOPSY PERFORMED? (Yes or no): NO
WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

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

FILED MAR 27 1990

FILED APR 09 1990

CERTIFIER

28a. 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.

28b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
28c. MEDICAL LICENSE NO.: 15325
28d. DATE SIGNED (Month, Day, Year): 3/26/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 2342 Ridge Rd Highland Ind

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): MAR 27, 90

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

000502

Cem #27-280-10 Homestead Gardens Master Add Sec 80 Lot 10 Bl 210

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

4.00