① 005275

HO 446782 x 829

Local No. 2636-88

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3 DATE OF DEATH (Mo Day Yr)
Henning Albin Forsberg	Male	December 17, 1988

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 (Month Day Year)	7 BIRTHPLACE (City and State or Foreign Country)
306-01-6157	90			May 22, 1898	Chicago, IL

8 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 ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Meridian Nursing Home	Dyer	Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (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	Elna Tolf	retired-VP Blaw Knox	Steel Foundry

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
IN	Lake	Hammond	7205 Knickerbocker Pkwy

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN?	15 RACE	16 DECEDENT'S EDUCATION (Elementary/Secondary (0-12) / College (1-4 or 5+))
Yes	No	46323	☒ No ☐ Yes	White	12

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
Otto W. Forsberg	Elizabeth Carlson

INFORMANT

19a INFORMANT'S NAME	19b MAILING ADDRESS	19c Relationship
Gayle T. Farmer	8511 Crestwood Ave. Munster, IN 46321	Niece

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION	20c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	December 23, 1988 Ridgelawn Cemetery	Gary, IN

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Thomas J. Burns	1045184	Burns-Kish Funeral Home #3004968, 8415 Calumet Ave. Munster, IN 46321

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	25 DATE PRONOUNCED DEAD (Month Day Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
1 PM	December 17, 1988	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. Bronchopneumonia — 2 weeks
DUE TO (OR AS A CONSEQUENCE OF)
b. [illegible] — 2 yrs.
DUE TO (OR AS A CONSEQUENCE OF)
c. Organic Brain Syndrome — 2 yrs.
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

28a WAS AN AUTOPSY PERFORMED? (Yes or no) — 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
[signature]		December 20, 1988

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Dr. Fred Adler M.D. 800 MacArthur Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] — 32 DATE FILED (Month, Day, Year): DEC 23, 88

CORONER OR MEDICAL EXAMINER 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)

000455 4.00

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1

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

DEC 23 1988

LAKE COUNTY HEALTH COMMISSIONER

FILED APR 12 1990

Anne N. Anton

#36-495

S/2 Vacated 172nd Street, Blk 45 * Unit 13 of Woodmar, Plat Book 18, Page 21, LCD adjoining lots 15 and 16 on the North

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