

First Natl Bank
 3701 E. Lincoln Hwy, Meriden, Conn
 INDIANA STATE BOARD OF HEALTH

Local No. 633-9011

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
 IN
 PERMANENT
 BLACK INK

1 DECEASED—NAME (Print Middle Last) MAX YAFFE				2 SEX Male		3a TIME OF DEATH 8:30 a.m.		3b DATE OF DEATH (Month Day Year) March 10, 1990	
4 SOCIAL SECURITY NUMBER 307-01-5926		5a AGE—Last Birthday (Years) 86		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Month Day Year) OCT. 3, 1903	
7 BIRTHPLACE (City and State or Foreign Country) Springfield, Illinois		8a WAS DECEDENT A U.S. VETERAN? No							
8b YEAR LAST SERVED IN U.S. ARMED FORCES?		9a PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER, Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
9b FACILITY NAME (If not institution give street and number) Meridian Nursing Center					9c CITY TOWN OR LOCATION OF DEATH Dyer			9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed		11 SURVIVING SPOUSE (If wife give maiden name) -		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Retired Owner			12b KIND OF BUSINESS, INDUSTRY Yaffe's Squire Shop & The Benay Shop		
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Munster			13d STREET AND NUMBER 1838 Tulip Lane		
13e ZIP CODE 46321		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)		16 RACE—American Indian, Black, White, etc. (Specify) White	
17 DECEASED'S EDUCATION (Specify only highest grade completed) 8		17 CEDECENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (11-4 or 5+)							
18 FATHER'S NAME (First Middle Last) Benjamin Yaffe					19 MOTHER'S NAME (First Middle Maiden Surname) Anna Cohn				
20a INFORMANT'S NAME (Type Print) Benay Yaffe				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1838 Tulip Lane, Munster, IN 46321			20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) March 13, 1990 - Elmwood Cemetery			21c LOCATION—City or Town, State Hammond, Indiana				
22a EMBALMER'S NAME Woodrow Bonoyan		22b EMBALMER'S LICENSE NO. FD01053135			23 WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FD01018573			25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME, INC. #FH83001512 4201 Indianapolis Boulevard East Chicago, Indiana 46312				
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. Bilateral bronchopneumonia Cerebral vascular accident									
26 PART II Other significant conditions & conditions contributing to death but not previously stated in Part I. 1990									
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) No			28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)				
29a CERTIFIER (Name, Title, Address, and Health Officer's Signature) Charles Johnson, M.D., 800 MacArthur Boulevard, Munster, Indiana 46321									
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c MEDICAL LICENSE NO. 01019251			29d DATE SIGNED (Month Day Year) 3/12/90				
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Fred Adler, M.D., 800 MacArthur Boulevard, Munster, Indiana 46321									
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>								32 DATE FILED (Month Day Year) March 16, 1990	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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	
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.					

DECEDENT

PARENTS

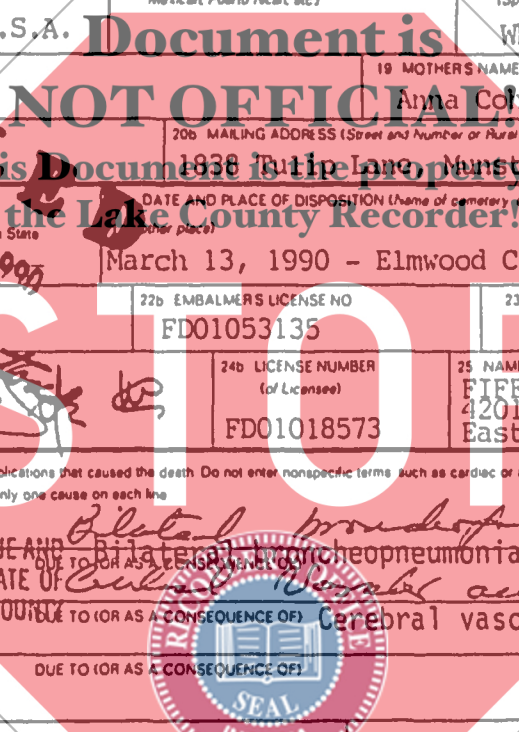
INFORMANT

DISPOSITION

CAUSE OF DEATH

HEALTH OFFICER

CORONER USE ONLY



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