92000250

INDIANA STATE BOARD OF HEALTH

Local No. 111-91

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Elizabeth Carter Hodson
2. SEX: Female
3a. TIME OF DEATH: 11:32P
3b. DATE OF DEATH (Month, Day, Yr): September 12, 1991
4. SOCIAL SECURITY NUMBER: 358-42-3654
5a. AGE—Last Birthday (Years): 44
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): July 31, 1947
7. BIRTHPLACE (City and State or Foreign Country): Urbana, Illinois
8a. WAS DECEDENT A U.S. VETERAN? N/A
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home XX Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): U.S. Rt. 41 & 119th Avenue
9c. CITY, TOWN OR LOCATION OF DEATH: Hanover Township
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John P. Hodson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Teacher
12b. KIND OF BUSINESS/INDUSTRY: Hanover School Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 10823 Schneider Place
13e. ZIP CODE: 46303
13f. INSIDE CITY LIMITS? XX No ☐ Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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+): 5+

PARENTS

18. FATHER'S NAME (First Middle Last): Bruce Conner Johnson
19. MOTHER'S NAME (First Middle Maiden Surname): Elizabeth Marie Peterson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John P. Hodson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10823 Schneider Pl., Cedar Lk, IN 46303
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Donation ☐ Entombment ☐ Other (Specify) ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 16, 1991 Calumet Park Crematory
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Not Embalmed
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER? ☐ No XX Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William F. Burdan
24b. LICENSE NUMBER (of Licensee): FD01007696
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURDAN FUNERAL HOME, INC. 12901 Wicker Ave., Cedar Lk, IN 46303

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. ASPHYXIA DUE TO INHALATION OF SMOKE

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): INCINERATION
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval: Between Onset and Death: UNKNOWN

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

27. WAS DECEDENT PREGNANT ON 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

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: Daniel D. Thomas, M.D.
29c. MEDICAL LICENSE NO: 16120
29d. DATE SIGNED (Month, Day, Year): SEPTEMBER 18, 1991

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN STREET, CROWN POINT, INDIANA 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): SEP 18 1991

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year): SEPT. 12, 1991
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no): NO
34d. DESCRIBE HOW INJURY OCCURRED: AUTOMOBILE ACCIDENT
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): STREET
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): HANOVER TOWNSHIP RT. 41 AND 119TH, CEDAR LAKE, INDIANA
34g. DATE PRONOUNCED DEAD (Month, Day, Year): SEPTEMBER 12, 1991
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: YES - DRIVER

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