3194-91 Local No.

LTIC# 55569

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. 93041055

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Hattie B. Bowman
2 SEX	Female
3a TIME OF DEATH	12:10 AM
3b DATE OF DEATH (Month Day Yr)	December 19, 1991
4 SOCIAL SECURITY NUMBER	306-36-9813
5a AGE—Last Birthday (Years)	83
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	January 4, 1908
7 BIRTHPLACE (City and State or Foreign Country)	New Salem, North Dakota
8a WAS DECEDENT A US VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution give street and number)	Our Lady Of Mercy Hospital
9c CITY TOWN OR LOCATION OF DEATH	Dyer
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife give maiden name)	Allen Bowman
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Homemaker
12b KIND OF BUSINESS/INDUSTRY	Own Home
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY TOWN OR LOCATION	St. John
13d STREET AND NUMBER	9175 Kardel Dr.
13e ZIP CODE	46373
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White etc (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	10

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Edward Fredricks
19 MOTHER'S NAME (First Middle Maiden Surname)	Sophia Zinn

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Allen Bowman
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	9175 Kardel Dr. St. John, Indiana 46373
20c Relationship	Husband

DISPOSITION

Field	Entry
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)	December 21, 1991 Memory Lane Memorial Park
21c LOCATION—City or Town, State	Schererville, Indiana
22a EMBALMER'S NAME	Edward F. Mullaney
22b EMBALMER'S LICENSE NO	FDO 1007176
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Edward F. Mullaney
24b LICENSE NUMBER (of Licensee)	FDO 1007176
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FH83001504 Fagen-Miller Funeral Gardens Inc 1920 Hart St. Dyer, Indiana 46311

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STOP

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	CEREBRAL ANOXIA	MINUTES
b DUE TO (OR AS A CONSEQUENCE OF)	CARDIAC STANDSTILL	MINUTES
c DUE TO (OR AS A CONSEQUENCE OF)	MYOCARDIAL INFARCTION	MINUTES
d DUE TO (OR AS A CONSEQUENCE OF)	ARTERIOSCLEROTIC HEART DISEASE	

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

DEC 20 1991

PART II Other significant conditions—Conditions contributing to death but not related to cause given in Part I: CONGESTIVE HEART FAILURE

Field	Entry
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)	

CERTIFIER

29a CERTIFIER (Check only one)
- [X] 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Doster J. Darus
29c MEDICAL LICENSE NO	E-470
29d DATE SIGNED (Month, Day, Year)	December 20, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr Darus 3100 45th Street Highland, IN 46322

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams M.D.
32 DATE FILED (Month, Day, Year)	December 20, 1991

CORONER USE ONLY

Field	Entry
33 MANNER OF DEATH	[ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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? (If yes specify driver, passenger, pedestrian etc)	

FILED

JUN 24 1993

Anna M. Antonas
AUDITOR LAKE COUNTY

00863

SAM ORLICH RECORDER
JUN 12 '93

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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