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Local No. 1880-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): ROSE SCHOBEL
2. SEX: Female
3a. TIME OF DEATH: 2:00A M
3b. DATE OF DEATH (Month Day Yr): August 1, 1993
4. SOCIAL SECURITY NUMBER: 425-48-8737
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR — Months / Days
5c. UNDER 1 DAY — Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): APR 13, 1912
7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN US ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife give maiden name): ANDREW SCHOBEL
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: HOME
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 2775 CASS STREET
13e. ZIP CODE: 46405
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? [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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): FRANK MALETICH
19. MOTHER'S NAME (First Middle Maiden Surname): KATHERINE SKOLAK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARGARET KUECHENBERG
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 220 N. LAKE PARK AVE, HOBART, IN 46342
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): AUG 5, 1993 RIDGELAWN CEMETERY
21c. LOCATION—City or Town, State: GARY, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO: FDO1006463
23. WAS DEATH REPORTED TO CORONER? [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003082 REES FUNERAL HOME, INC. 600 W. OLD RIDGE RD., HOBART, IN

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Lymphoma of Stomach Metastatic

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

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

THIS CERTIFIES THE ABOVE IS A TRUE COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. AUG 03 1993

Alexander S. Williams MD

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.

LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO: 01033934
29d. DATE SIGNED (Month Day Year): 8/3/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ASHWANI KUMAR MD, 3156 WILLOWCREEK ROAD, PORTAGE, IN 46368

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month Day Year): Aug. 3, 1993

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

FILED AUG 6 1993 [signature] AUDITOR LAKE COUNTY

RECEIVED FOR RECORD AUG 6 2 33 PM '93 SAM... ORLICH RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

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6.00

19-36-23 24 E 25 32 Sublive E. Gary Lots 23, 24, & 25 Bk. 2

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