10 CC'S

94023334

57812

Local No. 3140-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo Day Yr)
ANN		KAPLAN	FEMALE	JUNE 24, 1989

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)
313-07-1099	72			7-30-1916	CHICAGO, ILLINOIS

8 YEAR LAST SERVED IN U.S. ARMED FORCES? NONE

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
METHODIST HOSPITAL SOUTHLAKE CAMPUS	MERRILLVILLE	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	HAROLD KAPLAN	HOMEMAKER	AT HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GARY	9122 POTTAWATOMIE TRAIL

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46403		WHITE	12	

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
ISADORE GOODMAN	FANNIE SINGER

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
HAROLD KAPLAN	9122 POTTAWATOMIE TRAIL GARY, IN 46403	HUSBAND

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	TEMPLE BETH-EL CEMETERY JUNE 26, 1989	PORTAGE, IN

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James T. Burns	1374	BURNS FUNERAL HOME FHD: 8600018 10101 BROADWAY CROWN POINT, IN 46307

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

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)

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month, Day, Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
4:15 P.M.	JUNE 24, 1989	NO

CAUSE OF DEATH

SEE INSTRUCTIONS

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 Metastatic Breast Cancer	
Sequentially list conditions if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF) b	
	DUE TO (OR AS A CONSEQUENCE OF) c	
	DUE TO (OR AS A CONSEQUENCE OF) d	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Diabetes Mellitus

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

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

FILED
JUN 27 1989
JAN 28 1994

LAKE COUNTY HEALTH COMMISSIONER

SEE INSTRUCTIONS

CERTIFIER

29a. 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)
Anna M. Antonopoulos	50002600	6-26-89

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
DR. PETER MAVRELIS, M.D. 8895 BROADWAY MERRILLVILLE, INDIANA 46410

31 HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) June 27, 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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)

016730

SBH06-004 State Form 10140 (R/10-87) DEATH-PD