

6cc RETURN TO: 3717 W 122nd Pl
Crown Point IN 46307
INDIANA STATE BOARD OF HEALTH

Local No. 0321-92

CERTIFICATE OF DEATH

State No. 07-228-06

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) <u>Virginia Clemens Hosek Female</u>		2 SEX <u>Female</u>	3a TIME OF DEATH <u>12:50PM</u>	3b DATE OF DEATH (Month, Day, Yr) <u>February 8, 1992</u>	
4 SOCIAL SECURITY NUMBER <u>306-34-6516</u>	5a AGE—Last Birthday (Years) <u>57</u>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <u>MAY 3, 1934</u>	7 BIRTHPLACE (City and State or Foreign Country) <u>Hammond, IN</u>
8a WAS DECEDENT A U.S. VETERAN? <u>No</u>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <u>N/A</u>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <u>St. Anthony's Medical Center</u>		9c CITY, TOWN, OR LOCATION OF DEATH <u>Crown Point</u>	9d COUNTY OF DEATH <u>Lake</u>		
10 MARITAL STATUS (Specify) <u>Married</u>	11 SURVIVING SPOUSE (If wife, give maiden name) <u>Henry Hosek</u>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Paralegal</u>	12b KIND OF BUSINESS/INDUSTRY <u>Title Insurance</u>		
13a RESIDENCE—STATE <u>Indiana</u>	13b COUNTY <u>Lake</u>	13c CITY, TOWN OR LOCATION <u>Crown Point</u>	13d STREET AND NUMBER <u>3717 W. 122nd Pl.</u>		
13e ZIP CODE <u>46307</u>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <u>USA</u>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <u>White</u>	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1</u> College (1-4 or 5+)
18 FATHER'S NAME (First, Middle, Last) <u>Arthur</u>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elizabeth Clemens</u>			
20a INFORMANT'S NAME (Type/Print) <u>Henry Hosek</u>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3717 W. 122nd Pl., Crown Point, IN, 46307</u>		20c Relationship <u>Husband</u>	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>FEB 12, 1992 St. Mary's Cemetery</u>		21c LOCATION—City, Town, State <u>Crown Point, IN</u>	
22a EMBALMER'S NAME <u>Larry A. Geisen</u>		22b EMBALMER'S LICENSE NO. <u>FD09000013</u>		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <u>Larry A. Geisen</u>		24b LICENSE NUMBER (of Licensee) <u>FD09000013</u>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <u>Geisen Funeral Home, Inc. 109 N East St., Crown Point, IN 46307</u>	
26 PART I: Enter the disease, 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. <u>collapse of the lung</u> IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <u>due to (or as a consequence of) CHRONIC obstructive pulmonary disease</u>		APPROXIMATE Interval Between Onset and Death <u>12 20 91</u>		FILED FOR RECORD	
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. <u>Asymptomatic chronic obstructive pulmonary disease</u>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <u>NO</u>	
28b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		29. WAS DEATH REPORTED TO CORONER? (Yes or no)			
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of his knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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. MEDICAL LICENSE NO. <u>21432</u>		29d. DATE SIGNED (Month, Day, Year) <u>2-10-92</u>	
29b SIGNATURE AND TITLE OF CERTIFIER <u>A. J. Beckman</u>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <u>Arthur J. Beckman M. D. 12110 Grant Street, Crown Point, IN 46307</u>			
31. HEALTH OFFICER'S SIGNATURE <u>Alexander S. Williams, M.D.</u>		32. DATE FILED (Month, Day, Year) <u>February 11, 1992</u>			
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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, etc. <u>000253</u>			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder.
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
JUN 05 1995
SAM OLFICH
AUDITOR LAKE COUNTY