Appel & Appel

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 158

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): Elizabeth Fisher
2. SEX: Female
3a. TIME OF DEATH: 2:30A M
3b. DATE OF DEATH (Month, Day, Yr.): May 26,1993
4. SOCIAL SECURITY NUMBER: 304-42-5498
5a. AGE—Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): Feb. 14,1908
7. BIRTHPLACE (City and State or Foreign Country): Nashville, TN
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: No
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): James Fisher
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: IN
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Munster
13d. STREET AND NUMBER: 8124 Highland Place
13e. ZIP CODE: 46321
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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 +): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Tant
19. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Rohm

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Leslie Fisher
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4418 N. Paulina Chicago,IL 60640
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 29,1993 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, IN
22a. EMBALMER'S NAME: James Porras
22b. EMBALMER'S LICENSE NO.: 1045964
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Kristina D. Kish
24b. LICENSE NUMBER (of Licensee): 1021590
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN 46321

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. Fracture of left hip
DUE TO (OR AS A CONSEQUENCE OF):
b. Pulmonary embolism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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

FILED FEB 28 1996 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD FEB 29 96

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: Fred Adler M.D.
29c. MEDICAL LICENSE NO.:
29d. DATE SIGNED (Month, Day, Year): May 27, 1993

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Fred Adler, M.D. 800 MacArthur Blvd. Munster,IN 46321
31. HEALTH OFFICER'S SIGNATURE: [illegible] MD.
32. DATE FILED (Month, Day, Year): 5-28-93

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): 001162
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILE

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1

#11295