6CC

*ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0440-97 43367

State No.

TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

DECEDENT

1 DECEASED—NAME (First, Middle, Last): VELMA J. FRIZZELL
2 SEX: FEMALE
3a TIME OF DEATH: 7:15 PM
3b DATE OF DEATH (Month, Day, Yr): FEBRUARY 20, 1997
4 *SOCIAL SECURITY NUMBER: 404-40-2852
5a AGE—Last Birthday (Years): 65
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Mo. Day. Yr): JUNE 10, 1931
7 BIRTHPLACE (City and State or Foreign Country): KENTUCKY
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL XXX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE CAMPUS
9c CITY, TOWN, OR LOCATION OF DEATH: MERRILLVILLE
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): CHARLES FRIZZELL
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: MERRILLVILLE
13d STREET AND NUMBER: 6281 HAYES STREET
13e ZIP CODE: 46410
13f INSIDE CITY LIMITS: ☐ No XXX Yes
13g ON A FARM?: X No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? XXX ☐ 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+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): EVERETT PHELPS
19 MOTHER'S NAME (First, Middle, Maiden Surname): LILIA CHILDERS

INFORMANT

20a INFORMANT'S NAME (Type/Print): CHARLES FRIZZELL
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6281 HAYES ST., MERRILLVILLE, IN 46410
20c Relationship: HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 24, 1997 CHAPEL LAWN MEMORIAL GARDENS
21c LOCATION—City or Town, State: SCHERERVILLE INDIANA
22a EMBALMER'S NAME: DAVID W. SEMPLINSKI
22b EMBALMER'S LICENSE NO: FD08600686
23 WAS DEATH REPORTED TO CORONER? ☐ No XX Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Joan Savich
24b LICENSE NUMBER (of Licensee): FD086001292
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME, 1010 BROADWAY CROWN POINT, IN 46307 FDH83002445 ~~SAVICH & SEMPLINSKI FUNERAL DIRECTORS~~

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.

THIS CERTIFICATE SUPERSEDES PREVIOUS CERTIFICATE

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Glioblastoma — Approximate Interval Between Onset and Death: months
DUE TO (OR AS A CONSEQUENCE OF): b.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Part II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

FILED MAR 19 1997 SAM ORLICH AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH COMMISSIONER

27 WAS FEMALE PREGNANT OR WITHIN 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): N/A

CERTIFIER

29a CERTIFIER (Check only one): XXX 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: M. Kovacich MD
29c MEDICAL LICENSE NO: 01033371
29d DATE SIGNED (Month, Day, Year): 2-25-97
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. MICHAEL KOVACICH, 8777 BROADWAY, MERRILLVILLE, IN 769-7536

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): February 27, 1997

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? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

000950

Reg # 15-180-2

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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