* 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.

Local No. 293

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key # 30-624-10

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): Glenwood Cole
2. SEX: Male
3a. TIME OF DEATH: 6:45 P M
3b. DATE OF DEATH (Month, Day, Yr): December 2, 1997
4. *SOCIAL SECURITY NUMBER: 312-18-2567
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day. Yr): Sept. 22, 1921
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946
9. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9a. FACILITY NAME (If not institution, give street and number): 2119 Cardinal Drive
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): Maxine Speers
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman (Retired)
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 2119 Cardinal Drive
13e. ZIP CODE: 46312
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): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Foy Cole
19. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Henderson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Maxine Cole
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2119 Cardinal Dr. East Chicago, Indiana 46312
20c. Relationship: Wife

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): December 8, 1997 Evergreen Memorial Park
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.: FD08600238
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home 83001520, 4859 Alexander Avenue, East Chicago, Indiana 46312

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Carcinoma of the Colon
DUE TO (OR AS A CONSEQUENCE OF): b.
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

Approximate Interval Between Onset and Death

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 TO COMPLETE CAUSE OF DEATH? (Yes or no)

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97 DEC 17 PM 2:41 MORRIS W. CARTER

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: Gerri C. Browning MD
29c. MEDICAL LICENSE NO.: 0103136
29d. DATE SIGNED (Month, Day, Year): 12-4-97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): GERRI C. Browning MD 4320 First #320 E.C. IN.
31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Rayburich
32. DATE FILED (Month, Day, Year): 12-5-97

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.:

FILED DEC 17 1997 001054 SAM ORLICH AUDITOR LAKE COUNTY

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

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