

INDIANA STATE BOARD OF HEALTH

rec b

Local No. 1081-92

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>HENRY P. WOLFE</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>3:59P M</b>	3b DATE OF DEATH (Month, Day, Yr) <b>May 16, 1992</b>
4 SOCIAL SECURITY NUMBER <b>344-09-9130</b>	5a AGE—Last Birthday (Years) <b>84</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>SEP 8, 1907</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>ELK LANE, PENNSYLVANIA</b>		8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c PLACE OF DEATH (Check only one) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <b>ARR 13 1992</b>		

DECEDENT

9b FACILITY NAME (If not institution, give street and number) <b>ST. MARY MEDICAL CENTER</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>HOBART</b>	9d COUNTY OF DEATH <b>LAKE</b>
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>MARY L. SCADUTO</b>	12a DECEDENT'S USUAL OCCUPATION (Give details of work done during most of working life. Do not use retired) <b>SUPT. STORE &amp; SUPPLY</b>	
12b NAME AND KIND OF BUSINESS/INDUSTRY <b>AMERICAN BRIDGE CO.</b>		12c COUNTY OF BUSINESS <b>LAKE COUNTY</b>	
13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY, TOWN, OR LOCATION <b>HOBART</b>	13d STREET AND NUMBER <b>103 N. MICHIGAN AVENUE</b>

PARENTS

13e ZIP CODE <b>46342</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>WHITE</b>	17 DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>5</b>	
18 FATHER'S NAME (First, Middle, Last) <b>ANDREW M. WOLFE</b>			19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE MAE ORR</b>				

INFORMANT

20a INFORMANT'S NAME (Type/Print) <b>MARY L. WOLFE</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 N. MICHIGAN AVENUE, HOBART, IN 46342</b>	20c Relationship <b>Wife</b>
---	--	---	---------------------------------

DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>MAY 21, 1992 CALUMET PARK CEMETERY</b>	21c LOCATION—City or Town, State <b>MERRILLVILLE, INDIANA</b>
---	--	--

CAUSE OF DEATH

22a EMBALMER'S NAME <b>JAMES W. GHOLSTON</b>	22b EMBALMER'S LICENSE NO. <b>FDO1004194</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>	24b LICENSE NUMBER (of Licensee) <b>FDO1006463</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>REES FUNERAL HOMES-INC 600 W. RIDGE RD, HOBART, IN 46342</b>
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. <b>Cardiac arrest</b> <b>Coronary artery disease</b>		
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF)		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)		
PART II. Enter significant conditions or conditions contributing to death but not previously stated in Part I. <b>LAKE COUNTY HEALTH COMMISSIONER</b>		
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>N/A</b>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>

CERTIFIER

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my 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 SIGNATURE AND TITLE OF CERTIFIER <i>R. N. Barton MD</i>	29c MEDICAL LICENSE NO. <b>17667 In</b>	29d DATE SIGNED (Month, Day, Year) <b>5-18-92</b>
---	--	--	--

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>RR BARTON MD, 6101 MILLER AVENUE, GARY, IN 46403</b>	31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>	32 DATE FILED (Month, Day, Year) <b>May 18, 1992</b>
--	---	---

CORONER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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) <b>000710</b>		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

HOLD FOR FIRST AMERICAN TITLE