* 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.

Key #

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 01-20-96 State No. 12-14-17

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): Charles Leonard Hogan
2 SEX: Male
3a TIME OF DEATH: 11:15AM
3b DATE OF DEATH (Month Day Yr): May 2, 1996
4 *SOCIAL SECURITY NUMBER: 720-10-4788
5a AGE—Last Birthday (Years): 73
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day. Yr): JUL 9, 1922
7 BIRTHPLACE (City and State or Foreign Country): Kentland, IN
8a WAS DECEDENT A US VETERAN? No Yes
8b YEAR LAST SERVED IN US ARMED FORCES? Oct. 26 N/A 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): St.Margaret Mercy South Campus
9c CITY, TOWN OR LOCATION OF DEATH: Dyer
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Ellen Hogan\Upchurch
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipefitter
12b KIND OF BUSINESS/INDUSTRY: Local 597
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: St. John
13d STREET AND NUMBER: 9335 Keilman
13e ZIP CODE: 46373
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
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+):

PARENTS

18 FATHER'S NAME (First Middle Last): Leonard Hogan
19 MOTHER'S NAME (First, Middle, Maiden Surname): Lorraine Porter

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ellen Hogan\Upchurch
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9335 Keilman, St. John, IN. 46373
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MAY 6, 1996 Chapel Lawn Memorial Gardens
21c LOCATION—City or Town, State: Schererville, IN
22a EMBALMER'S NAME: Marty Andersen
22b EMBALMER'S LICENSE NO: FD01005205
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD09000013
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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: respiratory failure
DUE TO (OR AS A CONSEQUENCE OF) b: Pulmonary emphysema
DUE TO (OR AS A CONSEQUENCE OF) c: pulmonary fibrosis
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 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 PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

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, place, and due to the cause(s) and manner as stated
29b SIGNATURE AND TITLE OF CERTIFIER: Charles D. Egnatz MD
29c LICENSE NO: 19054
29d DATE SIGNED (Month Day Year): 5-3-96
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Charles Dyke Egnatz MD, 1326 US Rte 30, Schererville, IN 47580

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE
32 DATE FILED (Month Day Year): May 3, 1996

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

MAY 03 1996

FILED APR 15 1998 SAM ORLICH AUDITOR LAKE COUNTY

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CASH

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

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