

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

BURKE, MURPHY, CONSTANZA, CUFFY
15 N. FRANKLIN ST. STE 203
VAPOR, IN 46389

CERTIFICATE OF DEATH

State No.

Local No. 0714-97

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

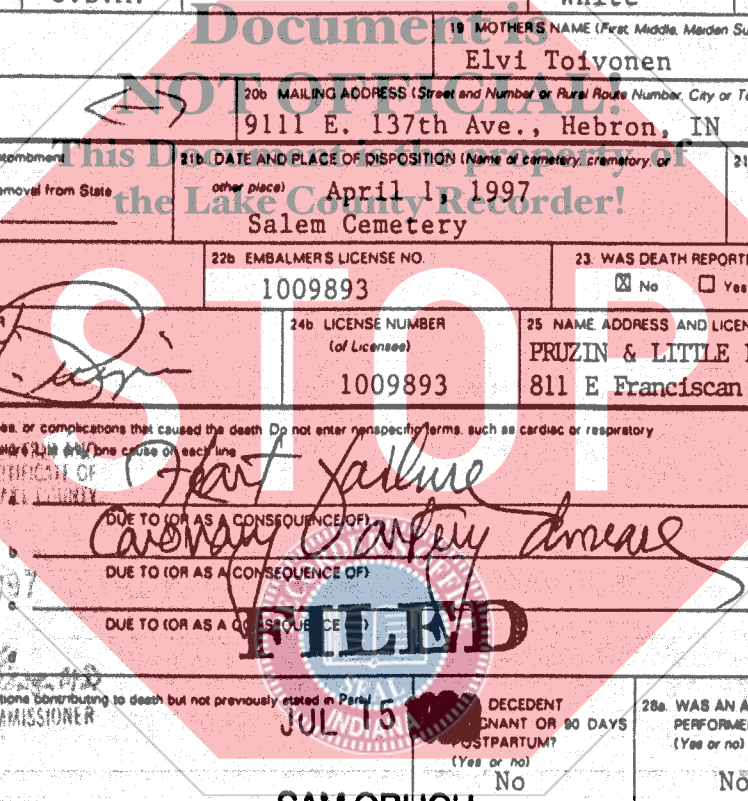
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) CHARLENE E. LAWSON				2 SEX Female		3a TIME OF DEATH 9:00 P M		3b DATE OF DEATH (Month, Day, Yr) March 28, 1997							
4. SOCIAL SECURITY NUMBER 304-40-2990		5a AGE—Last Birthday (Years) 58		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) August 15, 1938		7 BIRTHPLACE (City and State or Foreign Country) San Jose, California					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		9a. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				<input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence							
9b. FACILITY NAME (If not institution, give street and number) 9111 East 137th Avenue						9c. CITY, TOWN, OR LOCATION OF DEATH Hebron			9d. COUNTY OF DEATH Lake						
10. MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Lester L. Lawson			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Self-Employed			12b. KIND OF BUSINESS/INDUSTRY Ceramics							
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hebron			13d. STREET AND NUMBER 9111 East 137th Avenue								
13e. ZIP CODE 46341		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 +)					
18. FATHER'S NAME (First, Middle, Last) Lawrence Smith						19. MOTHER'S NAME (First, Middle, Maiden Surname) Elvi Toivonen									
20a. INFORMANT'S NAME (Type/Print) Lester L. Lawson				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 E. 137th Ave., Hebron, IN 46341				20c. Relationship Husband							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) April 1, 1997 Salem Cemetery				21c. LOCATION—City or Town, State Hebron, Indiana							
22a. EMBALMER'S NAME Thomas G. Pruzin				22b. EMBALMER'S LICENSE NO. 1009893				23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas G. Pruzin</i>				24b. LICENSE NUMBER (of Licensee) 1009893		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME PRUZIN & LITTLE FUNERAL SERVICE #3001261 811 E Franciscan Dr, Crown Point, IN 46307									
26. PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory. THIS COMPLETE SHEET OF PART I SHOULD BE ATTACHED TO ONE COPY OF EACH LINE IMMEDIATE CAUSE OF DEATH WITH THE LOCAL HEALTH OFFICER'S SIGNATURE. (Enter the immediate cause of death or condition resulting in death.) Heart failure Coronary artery disease										Approximate Interval Between Onset and Death 3-1997					
26. PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH COMMISSIONER										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			
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>Sam Orlich</i> AUDITOR LAKE COUNTY		29c. MEDICAL LICENSE NO. 01025644		29d. DATE SIGNED (Month, Day, Year) 4-3-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Kosin Thupvong, M.D., 8687 Concession Street, Merrillville, IN 46410 (219) 769-7800										31. HEALTH OFFICER'S SIGNATURE <i>Alexander ... M.D.</i>		32. DATE FILED (Month, Day, Year) April 3, 1997			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. 001142				<i>900 km</i>							



CK# 1623