*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. 98-7-94 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): CHARLES J. GLASSFORD

2 SEX: MALE

3a TIME OF DEATH: 4:10 A M

3b DATE OF DEATH (Month Day Yr): MARCH 30, 1999

4 *SOCIAL SECURITY NUMBER: 311-32-1271

5a AGE—Last Birthday (Years): 62

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo Day Yr): AUG. 12, 1936

7 BIRTHPLACE (City and State or Foreign Country): CROWN POINT, IN

8a WAS DECEDENT A U.S. VETERAN? YES

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1961

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution give street and number): ST. ANTHONY MEDICAL CENTER

9c CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): MARIED

11 SURVIVING SPOUSE (If wife give maiden name): BONNIE HILL

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CARPENTER

12b KIND OF BUSINESS/INDUSTRY: LOCAL UNION #1005

13a RESIDENCE—STATE: INDIANA

13b COUNTY: LAKE

13c CITY, TOWN OR LOCATION: CROWN POINT

13d STREET AND NUMBER: 10701 PORTER ST.

13e ZIP CODE: 46307

13f INSIDE CITY LIMITS? [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [XX] 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 complete): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): WILLIAM EDWARD GLASSFORD, SR.

19 MOTHER'S NAME (First Middle Maiden Surname): CAHTERINE MARIE COMERFORD

INFORMANT

20a INFORMANT'S NAME (Type/Print): BONNIE J. GLASSFORD

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10701 PORTER ST., CROWN POINT, IN46307

20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Burial [XX] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 4/2/99 N.W.IND. CREMATION SERVICES

21c LOCATION—City or Town, State: CROWN POINT INDIANA

22a EMBALMER'S NAME: GORDON L. JONES

22b EMBALMER'S LICENSE NO.: 1010711

23 WAS DEATH REPORTED TO CORONER? [XX] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: James E Burns

24b LICENSE NUMBER (of Licensee): 1009461

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME, 1101 BROADWAY CROWN POINT, IN 46307 FD083002445

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. Lung Cancer

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last:

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

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):

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

CERTIFIER

29a CERTIFIER (Check only one):
[XX] 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: R Drasga

29c MEDICAL LICENSE NO: 01031484

29d DATE SIGNED (Month Day Yr): March 31, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print): DR. RAY DRASGA, 8127 MERRILLVILLE ROAD, MERRILLVILLE, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE SIGNED (Month Day Year): 3/31/99

INJURY

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): MAR 31 1999

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian:

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

I CERTIFIED THIS IS A TRUE COPY OF DEATH CERTIFICATE ON FILE IN LAKE COUNTY HEALTH DEPT. 000548

#7-216-32-31

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