

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE / COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Local No. 654

St Date Issued Aug 23, 1999 *Franklin S. Premuda*
Hammond Health Commission

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) Joanna Boswinkle		2 SEX Female		3a TIME OF DEATH 2:25AM		3b DATE OF DEATH (Month Day Yr) August 20, 1999	
4 *SOCIAL SECURITY NUMBER 304-32-7788		5a AGE—Last Birthday (Years) 65		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) March 17, 1934		7 BIRTHPLACE (City and State or Foreign Country) Calumet City, IL					
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) 6443 Rhode Island Ave.				9c CITY, TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Mathew Boswinkle		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Housewife		12b KIND OF BUSINESS/INDUSTRY Home	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6443 Rhode Island Ave.	
13e ZIP CODE 46323		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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) Ernest Thews				19 MOTHER'S NAME (First Middle Maiden Surname) Irene Oakley			
20a INFORMANT'S NAME (Type/Print) Mathew F. Boswinkle		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6443 Rhode Island Ave. Hammond, IN 46323				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) August 23, 1999 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Schererville, Indiana			
22a EMBALMERS NAME James W. Gholston		22b EMBALMERS LICENSE NO FDE1004194		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Jard A. Letour</i>		24b LICENSE NUMBER (of Licenses) FDO8601585		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH19900009 Virgil Huber Funeral Home 7051 Kennedy Ave. Hammond, IN 46323			
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 Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF) b Chronic Obstructive Pulmonary DUE TO (OR AS A CONSEQUENCE OF) c PETER BENJAMIN LAKE COUNTY AUDITOR DUE TO (OR AS A CONSEQUENCE OF) d							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Metastatic breast Cancer Metastatic Bronchogenic Cancer				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		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>Salman Gailani</i>				29c MEDICAL LICENSE NO 1027970		29d DATE SIGNED (Month Day Year) (AUG) 8/20/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) S.D. GAILANI 9116 COLUMBIA AVENUE, MUNSTER, INDIANA 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Premuda M.D.</i>						32 DATE FILED (Month Day Year) August 23, 1999	
33 MANNER OF DEATH <input checked="" 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)	
34g DATE PRONOUNCED DEAD (Month Day Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc 00044E			

THO HAS RYAN
4704
INDIANAPOLIS
EAST CHICAGO
IN 46312

MOBILE COUNTY RECORDER
 FILED FOR RECORD
 OCT 06 1999
 9 OCT - 62 AM 10:48
 FILE OF INDIANA
 THROUGH BETWEEN
 UNDERLAND DEATH