* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there is no penalty for refusal.

Local No. 002-98

203083

TYPE/PRINT IN PERMANENT BLACK INK

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Key # 26-222-20

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

State No. 98084316

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

**DECEDENT**

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|
| JUDITH FROST | FEMALE | 6:30 a.m. | JANUARY 1,1998 |

| 4. *SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR (Months / Days) | 5c. UNDER 1 DAY (Hours / Minutes) | 6. DATE OF BIRTH (Month, Day, Yr.) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 307-40-5855 | 58 | | | NOVEMBER 5,1939 | HAMMOND,INDIANA |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a. PLACE OF DEATH (Check only one. See instructions) |
|---|---|---|
| NO | N/A | HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify) |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| WILLIAM J. RILEY HOSPICE HOUSE | MUNSTER | LAKE |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| MARRIED | DANA FROST | HOMEMAKER | OWN HOME |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| INDIANA | LAKE | GRIFFITH | 919 N. OAKWOOD AVE. |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE—American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5 +) |
| 46319 | ☐ No ☒ Yes | ☒ No ☐ Yes | U.S.A. | ☒ No ☐ Yes | WHITE | 12 | 0 |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| EUGENE FENSTERMAKER | GWEN DELP |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| DANA FROST | 919 N. OAKWOOD AVE. GRIFFITH,IN. 46319 | HUSBAND |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | JANUARY 5,1998 CALUMET PARK CEMETERY | MERRILLVILLE,IN. |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| RAYMOND E. WHITE | FD08700086 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Raymond E White Jr. | FD08700086 | KUIPER FUNERAL HOME FH83007500 9039 KLEINMAN RD.HIGHLAND,IN. 46322 |

**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. Metastatic Colon cancer | 8 months |
| 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. | |

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OCT 13 1999
PETER BENJAMIN
LAKE COUNTY AUDITOR

| PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I | 27. WAS DECEDENT PREGNANT OR WITHIN 1 YEAR OF POSTPARTUM? (Yes or no) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|---|
| | NO | NO | N/A |

**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 and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. MEDICAL LICENSE NO | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| C. MED M.D. 7305 CALUMET AVE., MUNSTER, IN 46321 | 01040750 | 1-2-98 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month, Day, Year) |
|---|---|
| Alexander S. Williams, M.D. | THIS CERTIFIES THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH NOW IN OUR OFFICE IN THE LAKE COUNTY HEALTH DEPT. JAN 02 1998 |

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY occurred |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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 |
|---|---|
| | 000808 |

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

9.00 E.P. CS

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

25 x 10