

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

State No.

Local No. 1407-95

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) EDWARD JACOBSEN		2 SEX MALE	3a TIME OF DEATH 1:46P	3b DATE OF DEATH (Month, Day, Yr) JUNE 23, 1995	
4 SOCIAL SECURITY NUMBER 318-30-5533	5a AGE—Last Birthday (Years) 59	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) May 13, 1936	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) 66 <input type="checkbox"/> Residence 66			
9a FACILITY NAME (If not institution give street and number) THE COMMUNITY HOSPITAL		9b CITY, TOWN OR LOCATION OF DEATH MUNSTER	9c COUNTY OF DEATH LAKE		
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Arlayne Grandt	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Owner & Operator	12b KIND OF BUSINESS/INDUSTRY Trucking Co.		
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 8012 Beech St		
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <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) Edward L. Jacobsen			
18 MOTHER'S NAME (First, Middle, Maiden Surname) Julia N. A.		20a INFORMANT'S NAME (Type/Print) Arlayne Jacobsen			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8012 Beech St. Munster, IN 46321		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) June 27, 1995 Oakland Memory Lanes		21c LOCATION—City or Town, State Dolton, IL	
22a EMBALMER'S NAME Brian T. Burns		22b EMBALMER'S LICENSE NO. 8601763	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) 1045184	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Homes #3004968 8415 Calumet Munster, IN 46321		
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) Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF) Acute myocardial infarction					
Conditions if any which pertain to the immediate cause stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)					
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) ---		
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>[Signature]</i> PETER BENJAMIN LAKE COUNTY AUDITOR		29c MEDICAL LICENSE NO. 31576	29d DATE SIGNED (Month, Day, Year) JUNE 26, 1995		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) WON-SHICK LOH, M.D. 9134 COLUMBIA AVENUE, MUNSTER INDIANA 46321					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> W. S. Williams, M.D.			32 DATE FILED (Month, Day, Year) June 26, 1995		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 (If date of injury is not known, give date of death) RAY 21 1994
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) 8012 Beech St			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No			

NOT OFFICIAL
This Document is the property of the Lake County Recorder

FILED

OCT 27 1995

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Ref Key # 40-99-30,22,24, & 29 Key #

900 CASH