* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 99-46-99

CERTIFICATE OF DEATH

2000 012349

2000 FEB 23 PM 1:34

State No.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

MOSES W. CARTER
CLERK ORDER

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED–NAME (First Middle Last): MARGARET M. BOLEN		2. SEX: Female	3a. TIME OF DEATH: 7:25PM	3b. DATE OF DEATH (Month Day Yr): September 30, 1999	
4. SOCIAL SECURITY NUMBER: 348-26-9905	5a. AGE - Last Birthday (Years): 80	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr): September 5, 1919	7. BIRTHPLACE (City and State or Foreign Country): West Frankfort, Illinois
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence		
9b. FACILITY NAME (If not institution, give street and number): 414 Madison Street		9c. CITY TOWN OR LOCATION OF DEATH: Hobart		9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Widowed	11. SURVIVING SPOUSE (If wife, give maiden name): NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Homemaker		12b. KIND OF BUSINESS INDUSTRY: Home	
13a. RESIDENCE - STATE: Indiana	13b. COUNTY: Lake	13c. CITY TOWN OR LOCATION: Hobart	13d. STREET AND NUMBER: 414 Madison Street		
13e. ZIP CODE: 46342	13f. INSIDE CITY LIMITS ☐ No ☒ Yes	13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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 completed): Elementary-Secondary (0-12): 11	College (1-4 or 5+)				

PARENTS

18. FATHER'S NAME (First, Middle, Last): Ezra Appelton	19. MOTHER'S NAME First, Middle Maiden Surname: Bessie Logan

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Barbara Butler	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State Zip Code): 4879 Creek Nation Blacktop, Mulkeytown, IL	20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): October 5, 1999 Denning Cemetery	21c. LOCATION - City or Town State: West Frankfort, Illinois
22a. EMBALMER'S NAME: James J. Krause	22b. EMBALMER'S LICENSE NO: FDO1006463	23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause	24b. LICENSE NUMBER (of Licensee): FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. CARCINOMA OF LUNG	6 months
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): FEB 22 2000	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

FILED
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 90 DAYS 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	No

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)
	01030107	10-04-99

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Bharat H. Barai MD, 125 E. 89th Avenue, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.

32. DATE FILED (Month Day Year): FEB 15 2000

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1