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

Local No. 0467-00

2000 017835

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

39196

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED–NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
FRANCES M. OWEN	Female	11:32AM	February 20, 2000

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 (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
353-10-7935	90			March 30, 1909	Indianola, Illinois

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 ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Mary Medical Center	Hobart	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
Widowed	NONE	Homemaker	Home

13a RESIDENCE - STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hobart	248 N. California Street

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+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
John Marshall	Bessie Krise

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
Carole McCord	463 W 700 N, Valparaiso, IN 46385	Daughter

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION - City or Town State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	February 22, 2000 Rossville Cemetery	Rossville, Illinois

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
James J. Krause	FDO1006463	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FDO1006463	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. Pulmonary fibrosis	
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)	

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)
Charles J. Rebesco MD FILED MAR 1 2000 PETER BENJAMIN LAKE COUNTY AUDITOR	0103652	2/22/00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print)

Charles J. Rebesco MD, 1500 S. Lake Park Avenue, Suite 304, Hobart, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander S. Williams III MD	February 22 2000

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, etc.

SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

Rees Funeral Home 600 W. Old Ridge Rd. Hobart, IN 46342