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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0498-94 2000 017837 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): BETTY JANE SCHOLEBO
2. SEX: Female
3a. TIME OF DEATH: 1:40A.M.
3b. DATE OF DEATH (Month, Day, Yr): February 20, 1994
4. *SOCIAL SECURITY NUMBER: 303-24-6884
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo, Day, Yr): NOV 18, 1924
7. BIRTHPLACE (City and State or Foreign Country): CLINTON, INDIANA
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: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE
9c. CITY, TOWN OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): JAMES W. SCHOLEBO
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: LAKE STATION
13d. STREET AND NUMBER: 2715 FLOYD STREET
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM? [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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) College (1-4 or 5+): 10

PARENTS

18. FATHER'S NAME (First, Middle, Last): KIBBY A. HOLLINGSWORTH
19. MOTHER'S NAME (First, Middle, Maiden Surname): HESTER JANE CUMMINS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JAMES W. SCHOLEBO
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2715 FLOYD ST, LAKE STATION, IN 46405
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FEB 24, 1994 GRACELAND CEMETERY
21c. LOCATION—City or Town, State: VALPARAISO, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER? [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOME, INC. 600 W. OLD RIDGE RD., 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): ASTROCYTOMA OF BRAIN — Approximate Interval Between Onset and Death: 1 yr

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

MAR 15 2000 — Alexander S. Williams MD

PART II. Other significant conditions: Conditions contributing to death but not previously stated in Part I: CARCINOMA OF BREAST

27. WAS DECEDENT PREGNANT OR 30 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

CERTIFIER

29a. CERTIFIER (Check only one):
- [X] 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: [signature]
29c. MEDICAL LICENSE NO: [illegible]
29d. DATE SIGNED (Month, Day, Year): 2-20-94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BHARAT H. BARAI MD, 125 E. 89TH AVENUE, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): [illegible] 1994

FILED MAR 15 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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.

01107

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

Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder! STOP
RECORDER'S OFFICE SEAL LAKE COUNTY INDIANA