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.

2000-052814

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 96-26

State No. ....

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

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	MARGARET E. WRIGHT
2. SEX	FEMALE
3a. TIME OF DEATH	9:25 PM
3b. DATE OF DEATH (Month, Day, Yr)	JANUARY 25, 1996
4. *SOCIAL SECURITY NUMBER	309-24-8564
5a. AGE—Last Birthday (Years)	70
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	DEC. 22, 1925
7. BIRTHPLACE (City and State or Foreign Country)	OHIO CO., KENTUCKY
8a. WAS DECEDENT A U.S. VETERAN?	no
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	no
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	East Chicago
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Robert G. Wright
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	Own Home
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Highland
13d. STREET AND NUMBER	3418 Franklin Street
13e. ZIP CODE	46322
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] 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 +)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	William Bishop
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Agnes Tichenor

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Mr. Robert G. Wright
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3418 Franklin St. Highland, IN 46322
20c. Relationship	Husband

DISPOSITION

Field	Entry
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)	January 29, 1996 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State	Schererville, Indiana
22a. EMBALMER'S NAME	David McCoy
22b. EMBALMER'S LICENSE NO.	FDO8700581
23. WAS DEATH REPORTED TO CORONER?	
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FDO1013507
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

FILED
AUG 15 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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. Aspiration
DUE TO (OR AS A CONSEQUENCE OF)
b. Alzheimer's Disease
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

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) no

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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. 30610

29d. DATE SIGNED (Month, Day, Year) Jan. 26, 1996

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Napoleon L. Santos, M.D. 8129 Kennedy Ave. Highland, IN 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE [signature]

32. DATE FILED (Month, Day, Year) 1-26-96

33. MANNER OF DEATH
[ ] Natural [ ] Pending Investigation
[ ] Accident
[ ] Suicide [ ] Could not be Determined
[ ] Homicide

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.

9.00
TI

Return
Sand Ridge
Ba Hgld.

92-3872
920003872

TICOR TITLE INSURANCE
Crown Point, Indiana

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