* 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. 0057-00 State No. ......

280844

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

TYPE/PRINT IN PERMANENT BLACK INK

120-44069 H/O

DECEDENT

1. DECEASED-NAME (First Middle Last): RUTH LYNDELL COOKE
2. SEX: Female
3a. TIME OF DEATH: 6:25PM
3b. DATE OF DEATH (Month Day Yr): January 9, 2000
4. SOCIAL SECURITY NUMBER: 316-03-7873
5a. AGE - Last Birthday (Years): 83
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo Day Yr): Jun 17, 1916
7. BIRTHPLACE (City and State or Foreign Country): JASONVILLE, IN
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES:
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): 8708 PARKWAY AVENUE
9c. CITY TOWN OR LOCATION OF DEATH: HIGHLAND
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: OWN HOME
13a. RESIDENCE - STATE: IN
13b. COUNTY: LAKE
13c. CITY TOWN OR LOCATION: HIGHLAND
13d. STREET AND NUMBER: 8708 PARKWAY AVENUE
13e. ZIP CODE: 46322
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): COMMODORE WILLIAMS
19. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE SUSAN PAYNE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DONNA IMMIG
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2039-38TH PLACE, HIGHLAND, IN 46322
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): Jan 13, 2000 ELMWOOD CEMETERY
21c. LOCATION - City or Town State: Hammond, IN
22a. EMBALMER'S NAME: C. WILLIAM MCCOY
22b. EMBALMER'S LICENSE NO.: FDO1013612
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: George L Bocken
24b. LICENSE NUMBER (of Licensee): FDO1042047
24c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, HAMMOND, IN 46323

CAUSE OF DEATH

25. 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) a. Mesothelioma — Approximate Interval Between Onset and Death: 1 month
DUE TO (OR AS A CONSEQUENCE OF) b.
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

I CERTIFY THIS TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JAN 10 2000
Alexander S Williams MD
LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause 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): No

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
2000 SEP 21 AM 9 08
MORRIS W. CARTER RECORDER

10000068781

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: [signature]
29c. MEDICAL LICENSE NO: 01032072
29d. DATE SIGNED (Month Day Year): 1/10/00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print): E. ROBIN, M.D., 9305 CALUMET AVENUE, MUNSTER, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S Williams, MD
32. DATE FILED (Month Day Year): January 10, 2000

FILED SEP 20 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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.:

01258

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

Walsh

9.00 TI Ac

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