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* 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

State No.....

Local No. 96-0316

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

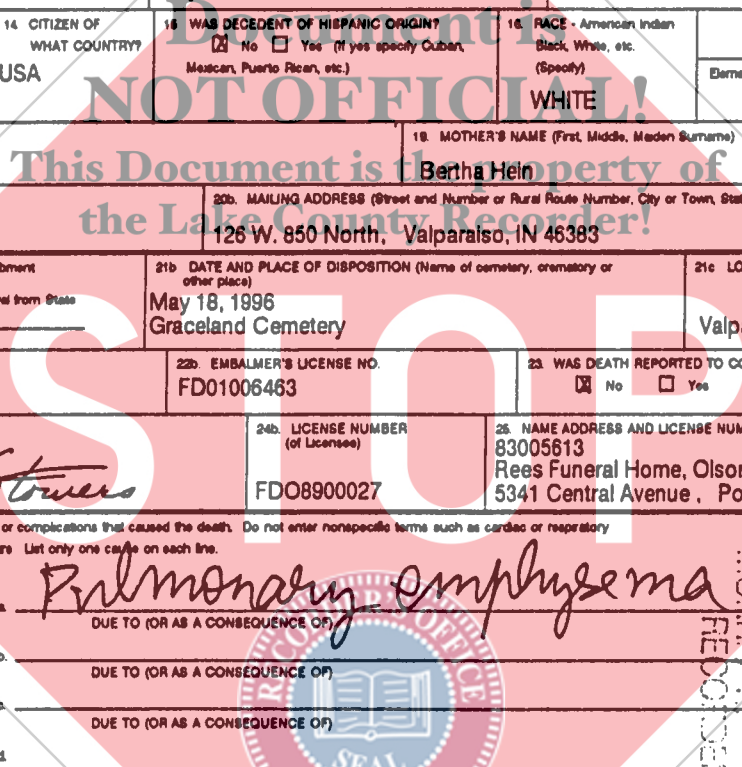
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) EMMA CATHERINE BOGUE		2. SEX Female	3a. TIME OF DEATH 8:53AM	3b. DATE OF DEATH (Month Day Yr) May 15, 1996
4. SOCIAL SECURITY NUMBER 305-20-9695	5a. AGE - Last Birthday (Years) 71	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jul 7, 1924
7. BIRTHPLACE (City and State or Foreign Country) Kokomo, IN	8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	
8c. PLACE OF DEATH (Check only one See instructions)				
HOSPITAL <input type="checkbox"/> Inpatient		OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		<input checked="" type="checkbox"/> Residence
9a. ER/Outpatient <input type="checkbox"/> DOA				
9b. FACILITY NAME (If not institution, give street and number) 172 S. Union		9c. CITY TOWN OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) James V. Bogue	12a. DECEASED'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 Gary	13d. STREET AND NUMBER 172 S. Union	
13e. ZIP CODE 46403	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY USA	15. WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16. RACE - American Indian (Black, White, etc. (Specify)) WHITE		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
18. FATHER'S NAME (First Middle, Last) Herman Westerman		19. MOTHER'S NAME (First Middle, Maiden Surname) Bertha Hein		
20a. INFORMANT'S NAME (Type/Print) Cathy Funk		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 W. 850 North, Valparaiso, IN 46383		20c. Relationship Daughter
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) May 18, 1996 Graceland Cemetery		21c. LOCATION - City or Town State Valparaiso, IN
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FD01006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth J. Stowers</i>		24b. LICENSE NUMBER (of Licensee) FDO8900027	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83005613 Rees Funeral Home, Olson Chapel 5341 Central Avenue, Portage, IN 46368	
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)		a. <i>Pulmonary emphysema</i>		
b. DUE TO (OR AS A CONSEQUENCE OF)				
c. DUE TO (OR AS A CONSEQUENCE OF)				
d. DUE TO (OR AS A CONSEQUENCE OF)				
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 DECEASED 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
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>K. Devanathan</i>		
29c. MEDICAL LICENSE NO. 01040141		29d. DATE SIGNED (Month Day Year) 5/16/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) RAJA DEVANATHAN MD, 1400 S. LAKE PARK AVE., SUITE 405, NOBART, IN 46342				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month Day Year) MAY 17 1996
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day Year) 01/11/96	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY (At home, farm, street, factory, office building, etc. (Specify))		35. DATE OF INJURY (Month Day Year) NOV 7 2000		
34e. DATE PRONOUNCED DEAD (Month, Day, Year)		34f. MOTOR VEHICLE ACCIDENT?		



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2001 MAY -7 AM 9:10

RETURN RECORDED DOCUMENT TO JAMIN LAKE COUNTY AUDITOR
Guaranteed Fidelity Title
1205 S. HALLOCK ST.
BAMETA IN 46310

#5523