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

Local No. 1739-01

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No.

LAKE COUNTY FILED FOR RECORD

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

2002 063716

2002 JUL 6 AM 10: 02

MORRIS W. CARTER RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED - NAME (First, Middle, Last): JACK COHEN
2. SEX: Male
3a. TIME OF DEATH: 6:01 AM
3b. DATE OF DEATH (Month, Day, Yr.): August 5, 2001
4. *SOCIAL SECURITY NUMBER: 392-14-3186
5a. AGE - Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): February 26, 1922
7. BIRTHPLACE (City and State or Foreign Country): MILWAUKEE WISC
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one) See instructions: HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital - South Lake Campus
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): IVA YATES
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): PAWNBROKER
12b. KIND OF BUSINESS/INDUSTRY: SELF EMPLOYED
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: MERRILLVILLE
13d. STREET AND NUMBER: 6098 MARYLAND STREET
13e. ZIP CODE: 46410
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): 12; College (1-4 or 5+): N/A

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): MORRIS COHEN
19. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCAH GLICK

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): IVA COHEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6048 MARYLAND STREET, MERRILLVILLE, IN
20c. Relationship: Wife

**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): August 7, 2001 BETH ISRAEL CEMETERY
21c. LOCATION - City or Town, State: PORTAGE, Indiana
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME & FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801

**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)
a. Card - resp - fail (handwritten) — Approximate interval Between Onset and Death: 1 mo. ad (handwritten)
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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. JUL 10 2002

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U): 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): —

FILED

JUL 16 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

**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] M.D.
29c. MEDICAL LICENSE NO.: 01-35956
29d. DATE SIGNED (Month, Day, Year): 8-6-01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. M. AJAM 8668 Broadway, Merrillville, IN 46410

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Susan J. Bart, D.O.
32. DATE FILED (Month, Day, Year): August 7, 2001
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: 001024
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): August 5, 2001
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

HOLD FOR FIRST AMERICAN TITLE

SDH06-004

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