

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. 278

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

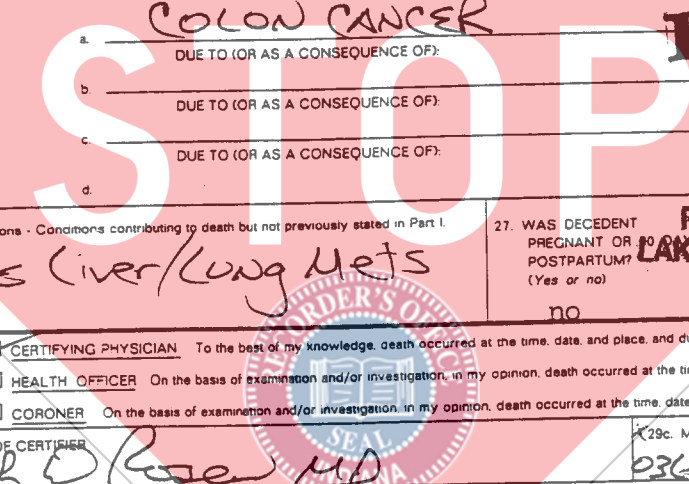
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Charlotte Fogelman		2 SEX Female	3a TIME OF DEATH 3:30p M	3b DATE OF DEATH (Month, Day, Yr) August 15, 1994
4 *SOCIAL SECURITY NUMBER 310-22-7598	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) November 28, 1925
7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois				
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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 4313 Alder Street		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) Jack Fogelman	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 East Chicago	13d STREET AND NUMBER 4313 Alder Street	
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+) ---		18 FATHER'S NAME (First, Middle, Last) Louis Emil		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Etti Davidson		20a INFORMANT'S NAME (Type/Print) Robin Fogelman		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10011 2-5th Avenue Apt. #14E New York, New York		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) August 17, 1994 Kneseth Isreal Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME N/A		22b EMBALMER'S LICENSE NO. 1045964	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) 1045184	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Avenue Munster, Indiana	
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. 2002 069169 COLON CANCER				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) COLON CANCER				FILED JUL 24 2002
a. DUE TO (OR AS A CONSEQUENCE OF):				
b. DUE TO (OR AS A CONSEQUENCE OF):				
c. DUE TO (OR AS A CONSEQUENCE OF):				
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. Extensive Liver/Lung Mets				27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) no
28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) no				PETER BENJAMIN LAKE COUNTY AUDITOR
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>Joseph O. Rose MD</i>			29c. MEDICAL LICENSE NO. 036-084120	29d. DATE SIGNED (Month, Day, Year) 8/17/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Univ of Chicago Medical Center				
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Semathy Rankin</i>				32. DATE FILED (Month, Day, Year) 8-18-94
33. MANNER OF DEATH <input 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)	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) 00152		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				

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11:00 AM DT

LEGAL DESCRIPTION

Lot 3 in Parcel One in Prairie Park Unit No. 5, a Subdivision in the City of East Chicago, Indiana, as per plat thereof, recorded in Plat Book 38 page 8, in the Office of the Recorder of Lake County, Indiana.

