620039215

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.

Local No. 8-10-01

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

129178

TYPE/PRINT IN PERMANENT BLACK INK

Chicago Title Insurance Company

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last): Miriam Dee Bogue			2. SEX: Female	3a. TIME OF DEATH: 12:10A M	3b. DATE OF DEATH (Month, Day, Yr.): April 18, 2001
4. *SOCIAL SECURITY NUMBER: 306-34-7487	5a. AGE—Last Birthday (Years): 2002 64	5b. UNDER 1 YEAR (Months, Days): 08704	5c. UNDER 1 DAY (Hours, Minutes):	6. DATE OF BIRTH (Mo, Day, Yr.): Aug. 25, 1936	7. BIRTHPLACE (City and State or Foreign Country): Whiting, IN
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None				

2002 NOV 25 AM 9:50 RECORDER

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): Community Hospital	9c. CITY, TOWN, OR LOCATION OF DEATH: Munster	9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Fred Bogue	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Surgical Technician	12b. KIND OF BUSINESS/INDUSTRY: Medical
13a. RESIDENCE—STATE: IN	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Griffith	13d. STREET AND NUMBER: 929 W. Glen Park
13e. ZIP CODE: 46319	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? [X] 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+): 2		
18. FATHER'S NAME (First, Middle, Last): Sidney Weiner	19. MOTHER'S NAME (First, Middle, Maiden Surname): Tillie Barton		
20a. INFORMANT'S NAME (Type/Print): David Lipman	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 235 1st Ave. NW Carmel, IN 46032	20c. Relationship: Son	
21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 20, 2001 Kneseth Israel Cemetery	21c. LOCATION—City or Town, State: Hammond, IN	
22a. EMBALMER'S NAME: ---	22b. EMBALMER'S LICENSE NO.: ---	23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee): 1021590	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet MUnster, IN 46321	

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. Multi organ failure	1wk.
DUE TO (OR AS A CONSEQUENCE OF)	b. Acute M.I.	1wk.
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	c. Acute Gastrointestinal	1wk.
DUE TO (OR AS A CONSEQUENCE OF)	d.	

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)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	---	---

NOV 25 2002 PETER BENJAMIN LAKE COUNTY AUDITOR

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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
K. Kalluri	010 43359	April 18, 2001

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): K. Kalluri, M.D. 800 MacArthur Blvd. Munster, IN 46321

31. HEALTH OFFICER'S SIGNATURE: Susan W Bess DO

32. DATE FILED (Month, Day, Year): NOV 25 2002

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

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY occurred
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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.
	no.

SDH06-004 State Form 10110 (R5/1-99)