* **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.

CHICAGO TITLE INSURANCE COMPANY 3569BT

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1642-98 42852

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MABEL FRANCES HARTFIELD
2. SEX: FEMALE
3a. TIME OF DEATH: 9:25 A M
3b. DATE OF DEATH (Month, Day, Yr): JULY 17,1998
4. *SOCIAL SECURITY NUMBER: 316-54-6374
5a. AGE—Last Birthday (Years): 90
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): JULY 16,1908
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, 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): WILLIAM J.RILEY MEMORIAL RESIDENCE
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): WIDOWED
11. SURVIVING SPOUSE (If wife, give maiden name):
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: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HIGHLAND
13d. STREET AND NUMBER: 3111 FRANKLIN ST.
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): FRANK L. JOHNSON
19. MOTHER'S NAME (First, Middle, Maiden Surname): CHRISTINE M.PETERSON

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JUDY H. BARRICK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8000 HICKORY LN. LINCOLN,NE. 68510
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): JULY 21,1998 ELMWOOD CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, IN.
22a. EMBALMER'S NAME: HENRY BLAKE
22b. EMBALMER'S LICENSE NO: FD01019406
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL HOMES FH83003035 2828 HIGHWAY AVE. HIGHLAND, IN. 46322

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Pneumonia	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. b.	DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.	DUE TO (OR AS A CONSEQUENCE OF):	

JUL 21 1998

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): NO
28. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

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) as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. MEDICAL LICENSE NO: 10279 70
29d. DATE SIGNED (Month, Day, Year): 7-20-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. S. GALANI 9116 COLUMBIA AVE MUNSTER IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): July 21, 1998

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:
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.

002476

900/KP CT

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