

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 0073-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) GEORGE LeRoy BOCKEN		2 SEX Male	3a TIME OF DEATH 7:16 PM	3b DATE OF DEATH (Month, Day, Yr.) January 11, 2007
4 *SOCIAL SECURITY NUMBER 316-09-2110	5a AGE—Last Birthday (Years) 84	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) July 21, 1922
7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA	8a. WAS DECEDENT A U.S. VETERAN? YES			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) THE 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) Dorothy Nash	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Funeral Director		12b. KIND OF BUSINESS/INDUSTRY Bocken Funeral Home
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Schererville		13d. STREET AND NUMBER 2371 Deerpath Dr-102
13e. ZIP CODE 46375	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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+) 1		18. FATHER'S NAME (First, Middle, Last) George N. Bocken		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Grace M. McNees		20. INFORMANT'S NAME (Type/Print) Dorothy Bocken		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2371 Deerpath Dr-102, Schererville, IN 46375		20c. Relationship Wife		
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) Jan 15, 2007 ELMWOOD CEMETERY		21c. LOCATION (City or Town, State) HAMMOND IN
22a. EMBALMER'S NAME JOHN C AULT		22b. EMBALMER'S LICENSE NO. FDO1013507	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John Ault</i>		24b. LICENSE NUMBER (of Licensee) FDO1013507	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH10600033 7042 Kennedy Avenue, Hammond, IN 46323	
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. THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE IMMEDIATE CAUSE (THIS REFERS TO THE CERTIFICATE OF DEATH TO BE FILED WITH THE DEEDS DIVISION OF THE CLERK OF COURTS). a. Myelodysplastic Syndrome DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) 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) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>Susan W Best, D.O.</i>		29c. MEDICAL LICENSE NO. 01041301
29d. DATE SIGNED (Month, Day, Year) 1/12/07		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) CHERYL L. MORGAN-IHRIG, M.D. 1630-45TH AVENUE, MUNSTER, IN 46321-		
31. HEALTH OFFICER'S SIGNATURE <i>Susan W Best, D.O.</i>		32. DATE FILED (Month, Day, Year) January 12, 2007		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) MAR 30 2007	34b. INJURY AT WORK? (Yes or no) NO	34c. DESCRIBE HOW INJURY OCCURRED 004238 11-
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) EGGY BOLINGA KATORA		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) LAKE COUNTY AUDITOR		
34f. DATE PRONOUNCED DEAD (Month, Day, Year)		34g. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. COMMUNITY TITLE COMPANY		
34h. FILE NO. 36945				

Deerpath Estates
Condo Phase 1 Unit #102
20-13-0315-0002

