



\* 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. 2372-02  
442126

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

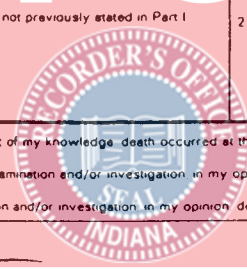
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Frances Golfis		2 SEX Female	3a TIME OF DEATH 10:43P	3b DATE OF DEATH (Month Day Yr) June 25, 2002	
4 *SOCIAL SECURITY NUMBER 331-30-2944	5a AGE—Last Birthday (Years) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Jan. 17, 1930	
7 BIRTHPLACE (City and State or Foreign Country) Canada		9a PLACE OF DEATH (Check only one. See instructions)			
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? None	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) 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) James Golfis	12a DECEASED'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 IN	13b COUNTY Lake	13c CITY TOWN OR LOCATION Dyer		13d STREET AND NUMBER 218 Summer Hill	
13e ZIP CODE 46311	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 6 College (1-4 or 5+) <input type="checkbox"/>		18 FATHER'S NAME (First, Middle, Last) Thomas Cappos			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Pauline		20a INFORMANT'S NAME (Type/Print) James Golfis			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Summer Hill Dyer, IN 46311		20c Relationship Husband			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) June 29, 2002 Ridgelawn Cemetery		21c LOCATION—City or Town, State Gary, IN	
22a EMBALMER'S NAME Kevin W. Kish		22b EMBALMER'S LICENSE NO. 1021590	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 License) 1045184	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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>Metastatic Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death			
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)					
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		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>Balappanath</i>		29c MEDICAL LICENSE NO. 01052677A	29d DATE SIGNED (Month Day Year) June 26, 2002		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) B. Keralavarma 1630 45th Munster, IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Sumant Bhatia</i>					
32 DATE FILED (Month Day Year) June 27, 2002					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Injury		34a DATE OF INJURY (Month Day Year) JUN 6 2007	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) REGGY TOLINCA KATONA LAKE COUNTY, INDIANA		34f LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g DATE OF DEATH (Month Day Year) JUN 25 2002		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



007433