





**INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

**Local No 000311**

**EDR No 00000176156**

**State No 003831**

1. Decedent's Legal Name (First, Middle, Last) <b>GLENN F COGSWELL</b>				1a. Maiden Name (If female)		2. Sex <b>MALE</b>	3. Time Of Death <b>12:10 PM</b>	4. Date Of Death (Month/Day/Year) <b>01/11/2011</b>		
5. Social Security Number <b>323-26-8319</b>		6a. Age - Yrs <b>78</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>02/18/1932</b>		8. Birthplace (City and State or Foreign Country) <b>DOLTON, IL</b>	
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival				10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street and Number) <b>COMMUNITY HOSPITAL</b>										
12. City Or Town, State, And Zip Code <b>MUNSTER, IN, 46321</b>					13. County Of Death <b>LAKE</b>			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>JOAN COGSWELL</b>			15a. (If Wife) Give Maiden Last Name <b>SLUSSER</b>			16. Decedent's Usual Occupation <b>PURCHASING MANAGER</b>		17. Kind Of Business/Industry <b>STEEL</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>			18b. City Or Town <b>SCHERERVILLE</b>			18d. Apt. No.	18e. Zip Code <b>46375</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18c. Street And Number <b>339 CYPRESS DRIVE</b>		19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>		20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>White</b>				
22. Father's Name (First, Middle, Last) <b>GROVER COGSWELL</b>				23. Mother's Name (First, Middle, Last) <b>HAZEL COGSWELL</b>			23a. Mother's Maiden Last Name <b>FIKE</b>			
24. Informant's Name <b>JOAN COGSWELL</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>339 CYPRESS DRIVE, SCHERERVILLE, IN 46375</b>						
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>OAKLAND MEMORY LANES</b>			25c. Location - City, Town, And State <b>DOLTON, IL</b>					
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>ANTHONY &amp; DZIADOWICZ FUNERAL HOME, INC., -MUNSTER, 9445 CALUMET AVE, MUNSTER, IN 46321</b>					27a. Funeral Home License Number: <b>FH83002916</b>			
27b. Signature Of Indiana Funeral Service Licensee: <b>LARRY D. ANTHONY, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01Q01447</b>				
28. Part I. Enter The <u>Chain Of Events</u> - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.										
Immediate Cause (Final Disease Or Condition Resulting In Death)		A. <u>CARDIOPULMUNARY ARREST</u> <small>Due to (Or As A Consequence Of):</small>						Approximate Interval: Onset To Death <b>IMMEDIATE</b>		
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last		B. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <small>Due to (Or As A Consequence Of):</small>								
		C. <u>HYPOTHYROIDISM</u> <small>Due to (Or As A Consequence Of):</small>								
		D. _____ <small>Due to (Or As A Consequence Of):</small>								
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I <b>CARDIAC ARRYTHMIA</b>						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year				33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined				
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38c. Apt. No.	38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: <b>CHIEDU JOSEPH NCHEKWUBE, BY ELECTRONIC SIGNATURE</b>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>CHIEDU JOSEPH NCHEKWUBE, 5495 BROADWAY, MERRILLVILLE, IN 46410</b>						44. License Number <b>01031281A</b>		45. Date Certified <b>02/01/2011</b>		
46. Additional Funeral Service Provider:						47. *Ages:				
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>FEB 01 2011</b>				
<b>AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)</b>										