* **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. 1627-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

95-031686

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): HELEN A. CUBBERLEY
2. SEX: Female
3a. TIME OF DEATH: 10:45 AM
3b. DATE OF DEATH (Month, Day, Yr.): July 17, 1995
5a. AGE—Last Birthday (Years): 89
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): August 5, 1905
7. BIRTHPLACE (City and State or Foreign Country): Hobart, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: ------
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): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Wallace Cubberley
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Book-Keeper
12b. KIND OF BUSINESS/INDUSTRY: Swartz & Company
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Lake Station
13d. STREET AND NUMBER: 3660 Iowa Street
13e. ZIP CODE: 46405
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): Charles Frobel
19. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Schroeder

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Wallace Cubberley
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3660 Iowa Street, Lake Station, In. 46405
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 20, 1995 Evergreen Memorial Park Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Alexis Thanos
22b. EMBALMER'S LICENSE NO.: FD08600505
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Alexis Thanos
24b. LICENSE NUMBER (of Licensee): FD08600505
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762, 7905 Broadway, Merrillville, In. 46410

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. Severe Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF)
b. Gangrene
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
c. Acute Renal failure
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): 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): 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark O Carter
29c. MEDICAL LICENSE NO.: 01036415
29d. DATE SIGNED (Month, Day, Year): 7/21/95

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Mark O. Carter, 295 South Wisconsin Street, Hobart, Indiana 46342
31. HEALTH OFFICER'S SIGNATURE: Alexis Thanos
32. DATE FILED (Month, Day, Year): July 27, 1995

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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.

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