

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT

667378

Local No. **183**

INDIANA STATE BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

State
No.

Benedict R. Wanko
1-150-110th St
Whiting, Ind.

DECEASED—NAME 1 HERMAN H. GOEBEL		SEX 2 MALE	DATE OF DEATH (MONTH DAY YEAR) 3 2-15-82
RACE—10 0 White (Black American Indian etc.) (Specify) 4 White	AGE—Last Birthday (Yr.) 5a 58	UNDER 1 YEAR 5b UNDER 1 DAY 5c	DATE OF BIRTH (Mo Day Yr.) 6 2-13-1924
CITY, TOWN OR LOCATION OF DEATH 7a Hammond		HOSPITAL OR OTHER INSTITUTION—Name (If not in prior give street and number) 7c St. Margaret Hospital	IF HOSP. OR INST. indicate DOA (OP, EM, RM, Impatient) (Specify) 7d Inpatient
STATE OF BIRTH (If not in U.S.A. name country) 8 Illinois	CITIZEN OF WHAT COUNTRY 9 U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10 Married	SURVIVING SPOUSE (If wife give maiden name) 11 Joan Bachmann
SOCIAL SECURITY NUMBER 13 314-20-0491	USUAL OCCUPATION (Give kind of work done during most of working life even if retired) 14 Operator (retired)	KIND OF BUSINESS OR INDUSTRY 14b Inland Steel Co.,	
RESIDENCE—STATE 15a Indiana	COUNTY 15b Lake	CITY, TOWN OR LOCATION 15c Hammond (Whiting P.O.)	
STREET AND NUMBER 15d 1506 Brown Avenue		IS RESIDENCE ON A FARM? 15e YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FATHER—NAME 16 Herman W. Goebel		MOTHER—MAIDEN NAME 17 Mina Larson	
INFORMANT—NAME (Type or print) 18a Joan Goebel, wife		RELATIONSHIP 18b wife	MAILING ADDRESS 18c 1506 Brown Ave., Whiting, Ind. 46394
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b Elmwood Cemetery	LOCATION 19c Hammond, Indiana
DATE (MONTH, DAY, YEAR) 20a Feb. 18, 1982		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO. CITY OR TOWN STATE, ZIP) 20b Baran & Son, Ind. 1235 119th St., Whiting, Ind. 46394	
To the best of my knowledge, death occurred at the time and place and due to the causes stated 21a (Signature) <i>[Signature]</i>		DATE SIGNED (Mo Day Yr.) 21b 2/16/82	HOUR OF DEATH 21c 11 A.M.
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d DR. M. FLOYD		MAILING ADDRESS—PHYSICIAN 21e 18141 Dixie Hwy #101 Homewood IL 60431	
HEALTH OFFICER—SIGNATURE 22a <i>[Signature]</i>		DATE RECEIVED BY LOCAL HEALTH OFFICER 22b MAR 3 1982	
PART I 23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE OR (a), (b) AND (c)) (a) Cardiac Arrest		Interval between onset and death 3 mins.	
(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Arterial Disease		Interval between onset and death years	
(c) DUE TO OR AS A CONSEQUENCE OF Hypertension		Interval between onset and death years	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not listed as cause in Part I (a), (b) and (c) End Stage Renal Failure		AUTOPSY (Specify Yes or No) 24 Yes	

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION

PARENTS

POSITION

M.D. OR D.O.

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

FUNERAL HOME No. 726

FUNERAL DIRECTOR'S LICENSE No. 702

LICENSE No. 4074

FILED

HAMMOND HEALTH COMMISSIONER

EMBALMER'S NAME **Martin Gabor**

FUNERAL DIRECTOR'S SIGNATURE *[Signature]*

MAR 3 1982

Date Issued

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPT.

Annals: B. Wanko

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