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Disposition Permit Issued / /
Provisional Certificate
 Yes No

780403

OCT 16 1984
LICENSE No. 1350

EMBALMER'S NAME
John C. Ault

FUNERAL HOME No. 280
FUNERAL DIRECTORS 1983
FUNERAL DIRECTORS LICENSE No. [Signature]
LAKE COUNTY HEALTH COMMISSIONER'S SIGNATURE [Signature]

Local No. 192884

INDIANA STATE BOARD OF HEALTH
CORONER'S CERTIFICATE OF DEATH

State No. _____

DECEASED—NAME 1. Leona C. Krueger			SEX 2. Female	DATE OF DEATH (MONTH, DAY, YEAR) 3. October 14, 1984
RACE—(e.g. White, Black, American Indian, etc.) (Specify) 4. White	AGE—Last Birthday (Yrs.) 5a. 57	UNDER 1 YEAR 5b. MONTHS	UNDER 1 DAY 5c. HOURS	DATE OF BIRTH (Mo., Day, Yr.) 6. 4/1/1927
CITY, TOWN OR LOCATION OF DEATH 7a. Munster		HOSPITAL OR OTHER INSTITUTION—(Name if not on other, give street and number) 7c. Community Hospital		COUNTY OF DEATH 7b. Lake
STATE OF BIRTH (If not in U.S.A. name country) 8. Indiana	CITIZEN OF WHAT COUNTRY 9. U.S.A.	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10. Married	SURVIVING SPOUSE (If wife, give maiden name) 11. Donald B. Krueger	
SOCIAL SECURITY NUMBER 13. 305-20-4850		USUAL OCCUPATION (Give kind of work done during most of working life, specify if part time) 14a. Insurance Clerk	KIND OF BUSINESS OR INDUSTRY 14b. Asbestos Workers Welfare Fund (Chicago, Ill)	
RESIDENCE—STATE 15a. Indiana	COUNTY 15b. Lake	CITY, TOWN OR LOCATION 15c. Munster		IF HOSP. OR INST. Indicate OCA, OP (Emer. Rm., Treatment) (Specify) 7d. E.R.
STREET AND NUMBER 15d. 9220 Marigold		IS RESIDENCE ON A FARM? 15e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) 12. No
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. Coleman Stephen Hall		MOTHER—MAIDEN NAME 17. Mary Frances Hobbes		
INFORMANT—NAME RELATIONSHIP 18a. Mr. Don Krueger [Husband]		MAILING ADDRESS 18b. 9220 Marigold Lane Munster, Indiana 46321		
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Burial		CEMETERY OR CREMATORY—FUNERAL HOME 19b. Memory Lane Memorial Park		LOCATION 19c. Schererville, Indiana
DATE (MONTH, DAY, YEAR) 20a. October 17, 1984		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 20b. Bocken Funeral Home, 7042 Kennedy, Hammond, IN		
On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the causes stated. 21a. Signature Daniel D. Thomas, M.D. by [Signature]		DATE SIGNED (Mo., Day, Yr.) 21b. 10-16-84	HOUR OF DEATH 21c. M	
NAME AND ADDRESS OF CERTIFIER (Type or Print) 21f. DANIEL D. THOMAS, M.D., CORONER, 2293 NORTH MAIN ST., CROWN POINT, IN.		PRONOUNCED DEAD (Mo., Day, Yr.) 21d. ON: 10-15-84	PRONOUNCED DEAD (Hour) 21e. AT: 6:39 A. M	
HEALTH OFFICER—SIGNATURE 22a. [Signature]		DATE RECEIVED BY LOCAL HEALTH OFFICER 22b. 10-16-84		
IMMEDIATE CAUSE 23. Cardiac arrest		Interval between onset and death Undetermined		
PART I (a) DUE TO OR AS A CONSEQUENCE OF: Due to arteriosclerotic heart & vascular disease		Interval between onset and death Interval between onset and death		
PART I (b) DUE TO OR AS A CONSEQUENCE OF: Interval between onset and death		Interval between onset and death Interval between onset and death		
PART I (c) OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to causes given in PART I (a) Interval between onset and death		Interval between onset and death Interval between onset and death		
ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 25a. Natural	DATE OF INJURY (Mo., Day, Yr.) 25b. _____	HOUR OF INJURY 25c. _____ M	DESCRIBE HOW INJURY OCCURRED 25d. _____	
INJURY AT WORK (Specify Yes or No) 25e. _____	PLACE OF INJURY—(At home, farm, street, factory, office building, etc.) (Specify) 25f. _____	LOCATION 25g. _____	STREET OR R.F.D. NO. CITY OR TOWN STATE AUDITOR LAKE COUNTY	