Stanley Huss

973222

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 47 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Charles Huss
2. SEX: M
3. DATE OF DEATH (Mo. Day, Yr.): Feb. 13, 1988
4. SOCIAL SECURITY NUMBER: 306-01-6599
5a. AGE—Last Birthday (Years): 88
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): Apr. 18, 1899
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Ind.
8. YEAR LAST SERVED IN US ARMED FORCES?:
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Elizabeth
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Core-Maker
12b. KIND OF BUSINESS/INDUSTRY: Foundry
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 505 Penrhyn Pl.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM:
13g. ZIP CODE: 46312
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): Anthony Huss
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Lepucki

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Richard Huss
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Penrhyn Pl. East Chicago, Ind.
19c. Relationship: Son

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Feb. 16 Holy Cross Cemetery
20c. LOCATION—City or Town, State: Calumet City, Ill
21a. SIGNATURE OF FUNERAL DIRECTOR: John B. Lesniak
21b. LICENSE NUMBER (of Licensee): 100549-1
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak Funeral Home, Inc 300160, 4918 Magoun Ave, East Chicago

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title < Nazari M.D.
23b. LICENSE NUMBER:
23c. DATE SIGNED (Month, Day, Year):

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 7:15 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): February 13, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

SEE INSTRUCTIONS

CAUSE OF DEATH

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Bronchopneumonia
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

FILED
APR 19 1988
Anna N. Antonich
AUDITOR LAKE COUNTY

APR 19 10 24 AM '88
FILED FOR RECORD
WILLIAM A. BLASTICK
RECORDER LAKE COUNTY
STATE OF INDIANA
S.S. No. 46307

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: [illegible handwriting]
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

SEE INSTRUCTIONS

CERTIFIER

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year):

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): R.L. Broomes M.D. 2404 Broadway East Chicago, Indiana 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: E. A. Campagna MD
32. DATE FILED (Month, Day, Year): 2-16-88

CORONER OR MEDICAL EXAMINER USE ONLY

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

925

SUBDIV. N.E. 3.20 T. 37 R. 9 ALL L37 BC
KEY # 30-16-37

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