

092547  
Local No. 4830-89

INDIANA STATE BOARD OF HEALTH  
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) Arthur C. Daege				2. SEX Male		3a. TIME OF DEATH 8:40 A.M.		3b. DATE OF DEATH (Month, Day, Year) December 14, 1989			
4. SOCIAL SECURITY NUMBER 317-09-2018		5a. AGE—Last Birthday (Years) 78		5b. UNDER 1 YEAR Months: Days:		5c. UNDER 1 DAY Hours: Minutes:		6. DATE OF BIRTH (Mo, Day, Yr) October 16, 1911		7. BIRTHPLACE (City and State or Foreign Country) Hanna, Indiana	
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
9b. FACILITY NAME (If not institution, give street and number) Merrillville Convalescent Center				9c. CITY, TOWN OR LOCATION OF DEATH Merrillville				9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Stephanie Grabos		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Machinist				12b. KIND OF BUSINESS/INDUSTRY Steel Industry			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Merrillville				13d. STREET AND NUMBER 2616 W. 82nd Avenue			
15a. ZIP CODE 46410		15b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input checked="" type="checkbox"/> College (1-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) Louis Doege						19. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Kurth					
20a. INFORMANT'S NAME (Type/Print) Stephanie Daege						20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2616 W. 82nd Avenue, Merrillville, In. 46410				20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 18, 1989 Calumet Park Cemetery				21c. LOCATION—City or Town, State Merrillville, Indiana			
22a. EMBALMER'S NAME Dennis P. Lapine				22b. EMBALMER'S LICENSE NO. FD08700141		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>				24b. LICENSE NUMBER (of Licensee) FD01005912		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410					
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) MULTIPLE SCLEROSIS DUE TO (OR AS A CONSEQUENCE OF) PART II. Enter the diseases, injuries, or complications contributing to death but not previously stated in Part I. 1989											
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No											
28. WAS AUTOPSY PERFORMED? No											
29. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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/COMMISSIONER <i>Jacob E. Pruitt</i> LAKE COUNTY HEALTH COMMISSIONER						29c. MEDICAL LICENSE NO. 15267		29d. DATE SIGNED (Month, Day, Year) 12 Dec 89			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jacob E. Pruitt; M.D., 7895 Broadway, Merrillville, Indiana 46410											
31. HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>											
32. DATE FILED (Month, Day, Year) Dec. 15, 1989											
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. 000024							

#15-147-A  
Indep. Hill 3rd St 89



APR 2 9 1990  
FILED FOR RECORDS  
OFFICE OF INDIANA STATE BOARD OF HEALTH

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