TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ALBERT DIEDERICH
2. SEX: MALE
3. 5 00P.M.
JANUARY 12,1990

4. SOCIAL SECURITY NUMBER: 310-22-3120 A
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): APRIL 6,1926
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana

8a. WAS DECEDENT A U S VETERAN? Yes
8b. YEAR LAST SERVED IN U S ARMED FORCES? 1946
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE

10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Priscilla Farkas
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machinist
12b. KIND OF BUSINESS/INDUSTRY: Tooling

13a. RESIDENCE—STATE: ILLINOIS
13b. COUNTY: COOK
13c. CITY, TOWN OR LOCATION: LANSING
13d. STREET AND NUMBER: 18331 SHERMAN STREET

13e. ZIP CODE: 60438
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM? X No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): John Diederich
19. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Stahl

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Priscilla Deiderich
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18331 Sherman St. Lansing, IL. 60438
20c. Relationship: Wife

FILED

APR 16 1990

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): January 15, 1990 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana

22a. EMBALMER'S NAME: Joseph C. Lauer
22b. EMBALMER'S LICENSE NO: FDE1043572
23. WAS DEATH REPORTED TO CORONER? ☐ No XX Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01018769
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FD#3002851 C.J. Huber 722-165th St. Hammond, Indiana 46320 for Schroeder Lauer Funeral Home

AUDITOR, LAKE COUNTY [signature]

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. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF)
b. METASTATIC CARCINOMA OF LARYNX
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: CHRONIC OBSTRUCTIVE LUNG DISEASE
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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)

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: [signature]
29c. MEDICAL LICENSE NO: 29277
29d. DATE SIGNED (Month, Day, Year): JANUARY 13 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ROBERT SMOLTZ 110 RIDGE ROAD MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): Jan 15 1990

CORONER 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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

615 4.00 CK

7-172-16 Bond Rec Amb All Lt

SBH06-004 DEA CERT/PO 1