

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 315-90 098062

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

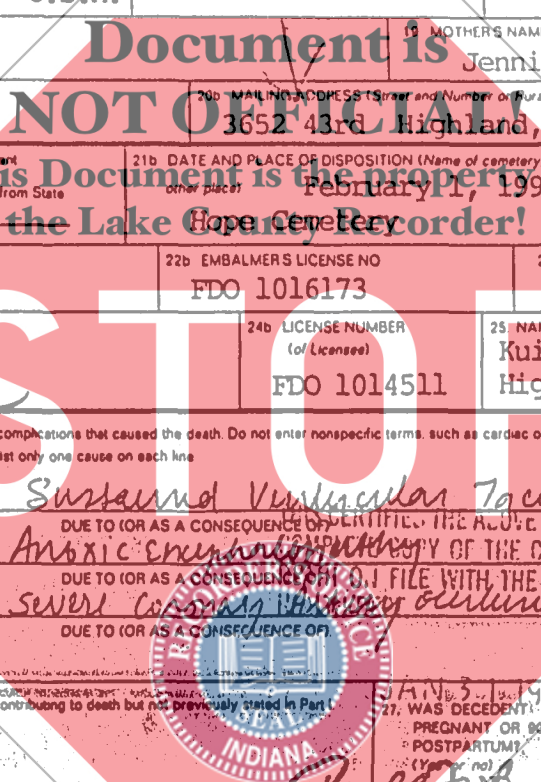
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED—NAME (First, Middle, Last) George Vander Meer | | 2. SEX Male | 3a. TIME OF DEATH 12:30 P.M. | 3b. DATE OF DEATH (Month, Day, Yr) January 30, 1990 | |
| 4. SOCIAL SECURITY NUMBER 558-26-0183 | 5a. AGE—Last Birthday (Years) 73 | 5b. UNDER 1 YEAR Months: _____ Days: _____ | 5c. UNDER 1 DAY Hours: _____ Minutes: _____ | 6. DATE OF BIRTH (Mo, Day, Yr) Sep. 13, 1916 | |
| 7. BIRTHPLACE (City and State or Foreign Country) Grand Rapids, MI. | 8a. WAS DECEDENT A U.S. VETERAN? Yes | | | | |
| 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945 | | 9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> 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) Grace Van Amstel | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Carpenter | | 12b. KIND OF BUSINESS/INDUSTRY Construction | |
| 13a. RESIDENCE—STATE Indiana | 13b. COUNTY Lake | 13c. CITY, TOWN, OR LOCATION Highland | 13d. STREET AND NUMBER 3652 43rd | | |
| 13e. ZIP CODE 46322 | 13f. 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+): _____ | | 18. FATHER'S NAME (First, Middle, Last) Frank Vander Meer | | | |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie De Boer | | 20a. INFORMANT'S NAME (Type/Print) Grace Vander Meer | | | |
| 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3652 43rd Highland, Indiana 46322 | | 20c. Relationship Wife | | | |
| 21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) February 11, 1990 Hope Cemetery | | 21c. LOCATION—City or Town, State Highland, Indiana | |
| 22a. EMBALMER'S NAME Edgar Gleim | | 22b. EMBALMER'S LICENSE NO. FDO 1016173 | | 23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i> | | 24b. LICENSE NUMBER (of Licensee) FDO 1014511 | | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500 | |
| 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) Sustained Ventricular Tachycardia | | | Approximate Interval Between Onset and Death 1 day | | |
| b. Anoxic encephalopathy | | | 1 day | | |
| c. Severe coronary artery disease | | | 1 year | | |
| PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. | | | | | |
| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) 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) 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, 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 <i>A. Gunch</i> Lake County Health Commissioner | | | |
| 29c. MEDICAL LICENSE NO. 01029887 | | 29d. DATE SIGNED (Month, Day, Year) 1-31-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) A. R. HOHI MD - 9122 COLUMBIA MUNSTER | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>A. R. Hohl</i> | | | | 32. DATE FILED (Month, Day, Year) JAN 31, 90 | |
| 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) MAY 01 1990 | 34b. TIME OF INJURY FILED | 34c. INJURY AT WORK? (Yes or no) no | |
| 34d. DESCRIBE HOW INJURY OCCURRED | | 34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) MAY 01 1990 | | | |
| 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. no | | 34i. SIGNATURE OF CORONER <i>David N. Antone</i> | | | |



Reg # 27-311-11
 JAN 31 1990

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