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NW COR. N2 NE S.33 T.33 R.8 .387A 12

225 x 75 ft.

Key #3-63-11

Unit #2

Local No. 389-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	Lester G. Steuer
2. SEX	Male
3a. TIME OF DEATH	1:00pm
3b. DATE OF DEATH (Month, Day, Yr)	Feb. 10, 1991
4. SOCIAL SECURITY NUMBER	307-20-1793
5a. AGE—Last Birthday (Years)	68
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	July 30, 1922
7. BIRTHPLACE (City and State or Foreign Country)	Crown Point, IN
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: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Anthony's Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Crown Point, IN
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Ila Fauser
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Mechanic
12b. KIND OF BUSINESS/INDUSTRY	Service Station
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Lowell
13d. STREET AND NUMBER	18903 Harrison St.
13e. ZIP CODE	46356
13f. INSIDE CITY LIMITS	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Carl Steuer
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Linia Zander

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Ila Steuer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	18903 Harrison St. Lowell, IN 46356
20c. Relationship	Spouse

DISPOSITION

Field	Entry
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)	Feb. 12, 1991 Oakland Memory Lanes
21c. LOCATION—City or Town, State	Dolton, IN
22a. EMBALMER'S NAME	Kenneth P. Sheets
22b. EMBALMER'S LICENSE NO.	FD08900045
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Kenneth P. Sheets
24b. LICENSE NUMBER (of Licensee)	FD08900045
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Sheets Funeral Home 604 Commercial Lowell, IN 46356 FD83004277

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. Bronchogenic Carcinoma & [illegible]

DUE TO (OR AS A CONSEQUENCE OF)

b. Chronic obstructive airway disease

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

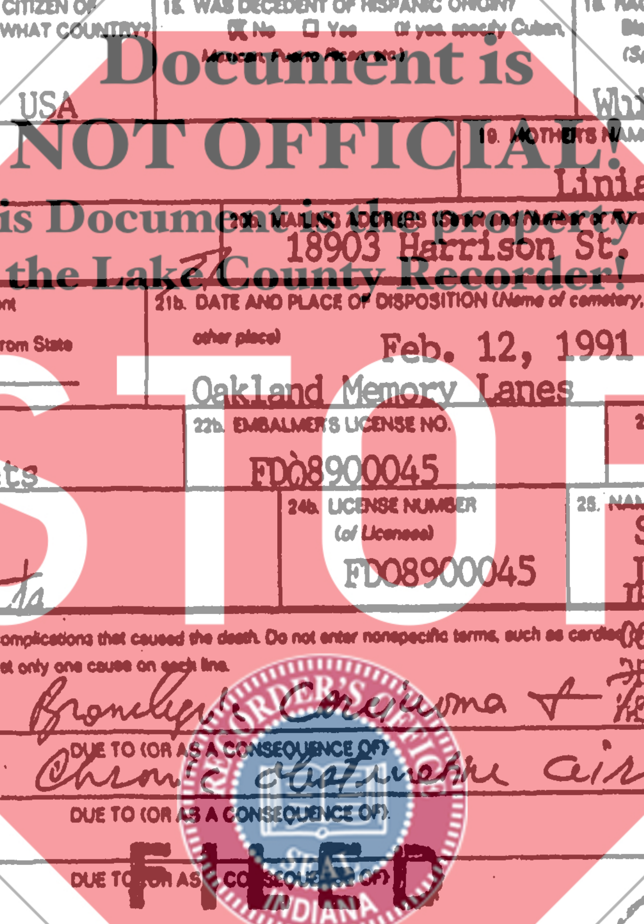
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)



FILED

FEB 27 1991

Auditor Lake County

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE [illegible] LAKE COUNTY HEALTH DEPT.

FEB 20 1991

LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA FILE S.S. 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c. MEDICAL LICENSE NO.	01030518
29d. DATE SIGNED (Month, Day, Year)	FEB. 14, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Srisuwananukorn Sompop MD 8695 Connecticut Merrillville, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year)	Feb. 20, 1991

CORONER USE ONLY

Field	Entry
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.	

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SBH06-004 State Form 10110 (R2/2-89) DEA CERT/PD 1