THIS CERTIFIES THE FOLLOWING IS A TRUE AND INDIANA STATE BOARD OF HEALTH COMPLETE COPY OF DEATH ON FILE WITH THE 199 91009155 MAR 0 1 1988 Frank 9. Juni Line. HAMMOND HEALTH DEPARTMENT. CERTIFICATE OF DEATH ocal No. Hammond Health Commissioner TYPE/PRINT DECEASED-NAME MIDDLE LAST FIRST 2. SEX 3 DATE OF DEATH (Mo. Day, Yr) Esther Female February 29, 1988 rouse IN 60 AGE—Last Birthday 4 SOCIAL SECURITY NUMBER 56 UNDER 1 YEAR SC UNDER I DAY 6 DATE OF BIRTH (Month | 7 BIRTHPLACE (City and State or Foreign Country) PERMANENT Feb. 14,1928 Days Minutes 309-24-9904 Hammond, Indiana **BLACK INK** B YEAR LAST SERVED IN US ARMED FORCES? NOTICE 9a PLACE OF DEATH (Check only one See instructions) HOSPITAL Inpatient C ER/Outpatient C DOA OTHER Nursing Home Residence Other (Specify) BC CITY, TOWN OR LOCATION OF DEATH 9d COUNTY OF DEATH 9b FACILITY NAME (If not institution, give street and number) DECEDENT St. Margaret Hospital Hammond Lake 12ª DECEDENT'S USUAL OCCUPATION 126 KIND OF BUSINESS/INDUSTRY 11. SURVIVING SPOUSE 10. MARITAL STATUS-Married (Give kind of work done during most of working life Never Married, Widowed Bus Driver Married (Society) Kurt E. Krause L.C.E.O.C. 13d STREET AND NUMBER 13c CITY, TOWN, OR LOCATION 134 RESIDENCE-STATE 13b COUNTY 4630 Johnson Ave., Indiana Lake Hammond 14 WAS DECEDENT OF HISPANIC ORIGIN? 16 DECEDENT'S EDUCATION 13f. FARM 139 ZIP CODE 15 RACE-American Indian, 130 INBIDE CITY LIMITST (Yes or no) (Specify No or Yes - If yes, specify Gubi Mexican Puerto Rican, etc.) ZDCNo Black, White, etc. (Specify only highest grade comple Elementary/Secondary (0-12) (Soecely) College (1-4 or 5 +) 46327 Yes No Specky White 17. FATHER'S NAME (First Middle, Last) **PARENTS** ŋ Kish Esther. Behary. John THE SALTIC ADDIBLES Street and Number or Rural House Number City or Town State Zip Code) 19c Relationship INFOHMANTS NAME (Type/Print) INFORMANT 4630 Johnson Ave., Hammond, Indiana 4632D Husband Kurt E. Krause 80 DATE AND PLACE OF DISPOSITION (Name of con other place) March 3, 1988 20c LOCATION-CRY or Town, State 20. METHOD OF DISPOSITION ☐ Cremetion Burial Donation Hammond, Indiana Other (Specify) DISPOSITION 🕥 OPERAL HOME 21. SIGNATURE OF FUNERAL DIRECTOR OTTLEHAYNE FUNERAL HOME, INC. FDH 3002885 5746 Hohman Ave., Hammond, Indiana 46320 23c. DATE SIGNED 58b.29 (Month, Day, 148) 1 2/29/88 PRONOUNCING Complete Hems 23a-c only when certifying physician is not available at time of death 236 LICENSE NUMBER 9000.2: B. Was PHYSICIAN ONLY 27487 Signature and Title < to certify cause of death ITEMS 24-26 MUST 28 WAS CASE REFERRED TOTMEDICAL EXAMINERYCONGNERY BE COMMPLETED BY 24. TIME OF DEATH 25. DATE PRONOUNCED DEAD (Mighth, Day, Year) PERSON WHO 3/88 MI 3125 P February 29 PRONOLINCES DEATH .0 Enter the diseases injuries, or complications that caused the death ()o not enter the mode of dying such as cardiac or respiratory Approximate Interval Between $\overline{\sim}$ arrest shock or heart failure. List only one cause on each line (Congestive heart fillure) ada, IMMEDIATE CAUSE (Final disease or condition DUE TO TOR AS A CONSEQUENCE OF (Renal failure)

DUE TO TOR AS A CONSEQUENCE OF (Cardiopulmonary arrest) 3 da resulting in death) SEE INSTRUCTIONS Š 408 if any, leading to immediate cause Enter UNDERLYING CAUSE (Disease or injury Mucous plugging of that initiated events trachea) resulting in death) LAST 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO 28s. WAS AN AUTOPSY CAUSE OF PART II. Other significant conditions contributing to death but not resulting in the underlying of PERFORMED? COMPLETION OF CAUSE (Yes or no) angrea OF DEATH? (Yes or no) NO (Electrolyte (Cerebral anoxia) 29a CERTIFIER CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has p (Check only SEE NSTRUCTIONS To the best of my knowledge, death occurred due to the cause(s) and manner as stated one) 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(a) and recovered. FEB 27 1991 To the best of my knowledge, death occurred at the time, date and pixce, and due to the cause(s) and manner as stated CERTIFIER MEDICAL EXAMINER CORONER HEALTH OFFICER On the besis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the 29c. LICENSE N 296 SIGNATURE AND TITLE OF CERTIFIER ames B. Washis 27487 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo/Print) 5500 Hohman Avenue, Hammond, Indiana 46320 J. Walsh, M.D. MAR O 1 1988 31. HEALTH OFFICER'S SIGNATURE HEALTH mudam D **OFFICER** DATE OF INJURY 34d. DESCRIBE HOW INJURY OCCURRED 34c INJURY AT WORK? 33. MANNER OF DEATH TIME (Month Day, Year) (Yes of no) INJURY ☐ Natural Pending CORONER OR I MEDICAL Accident EXAMINER USE 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 34e. PLACE OF INJURY -- At home, farm, street, factory, office ☐ Suicide Could not be ONLY Homocide 0181938H06-004 State Form 10110 (R/10-87) DEATH A/PD 1