91018828

LTIC #51331

Local No. 4696-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

LAWYERS TITLE INS. CORP.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	GUSTAV F. FRANK
2. SEX	Male
3a. TIME OF DEATH	3:15 AM
3b. DATE OF DEATH (Month, Day, Yr)	November 30, 1989
4. SOCIAL SECURITY NUMBER	305-30-4731
5a. AGE—Last Birthday (Years)	90
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	July 11, 1899
7. BIRTHPLACE (City and State or Foreign Country)	Tolleston, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	None
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Rose Banaszak
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	Boat Building
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Merrillville
13d. STREET AND NUMBER	118 E. 73rd Ave.
13e. ZIP CODE	46410
13f. INSIDE CITY LIMITS	☐ No XX Yes
13g. ON A FARM?	XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XX 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+)	8

PARENTS

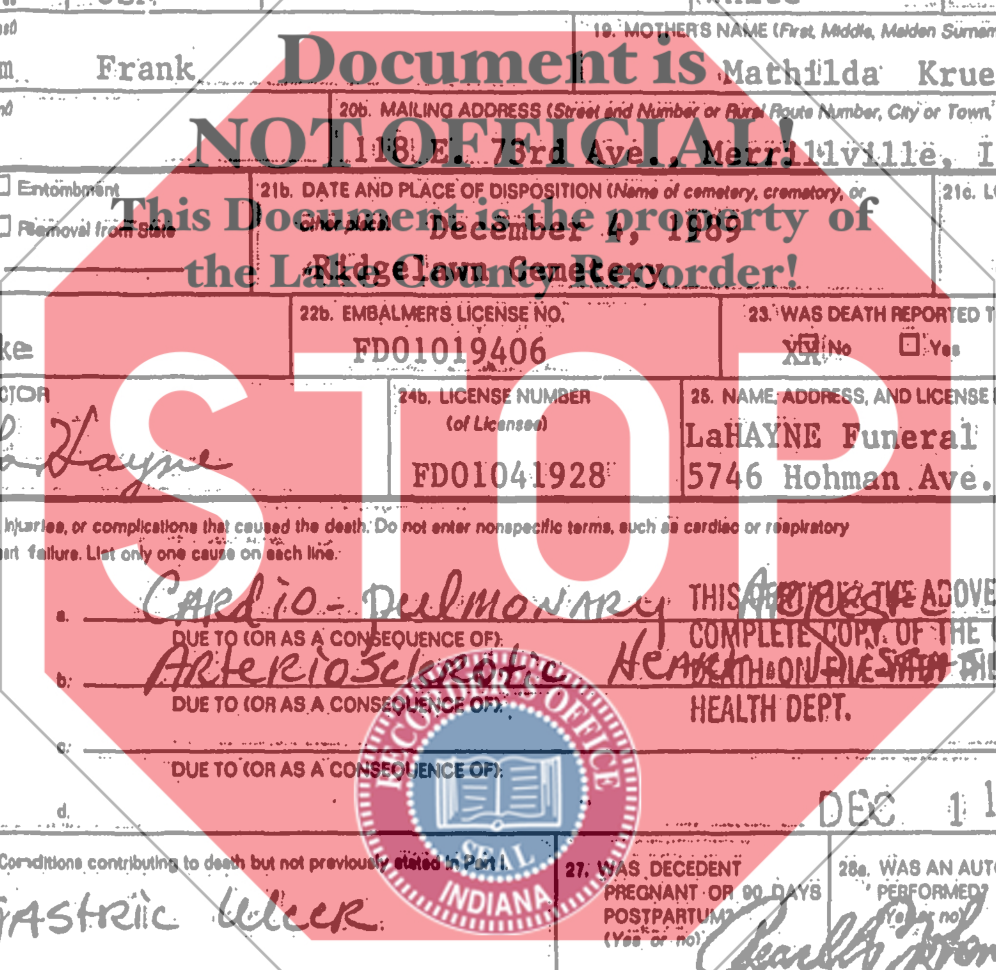
Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Wilhelm Frank
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Mathilda Krueger

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Rose Frank
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	118 E. 73rd Ave., Merrillville, Ind. 46410
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 4, 1989 Ridgelawn Cemetery
21c. LOCATION—City or Town, State	Gary, Indiana
22a. EMBALMER'S NAME	Henry J. Blake
22b. EMBALMER'S LICENSE NO.	FD01019406
23. WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Eldon V. LaHayne
24b. LICENSE NUMBER (of Licensee)	FD01041928
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	LaHAYNE Funeral Home, Inc., FH83002885 5746 Hohman Ave., Hammond, Indiana 46320



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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Cardio-pulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

b. Arteriosclerotic Heart Disease — Approximate Interval Between Onset and Death: years

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

THIS ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

DEC 1 1989

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

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)

Pearl B. Johnson, M.D.
LAKE COUNTY HEALTH COMMISSIONER

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	A. J. Krsek M.D.
29c. MEDICAL LICENSE NO.	16778
29d. DATE SIGNED (Month, Day, Year)	Nov. 30, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	A. J. KRSEK M.D. 101 Michigan Hobart, Ind. 46342

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Pearl B. Johnson M.D.
32. DATE FILED (Month, Day, Year)	~~Nov~~ DEC 1, 89

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.

FILED

APR 10 1991

Anna N. Anton
AUDITOR LAKE COUNTY

00968

6.00

Key# 15-28-48
W. 60 Ft. of E. 300 Ft. of S. 300 Ft. of SE1/4 of SW1/4 NW1/4 S15 T35 R8 1.31 AC.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

91018828

Local No. 4696-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

LTIC #51331

State No. LAWYERS TITLE INS. CORP. ONE PROFESSIONAL CENTER ... 215 ... IN 46307

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): GUSTAV F. FRANK
2. SEX: Male
3a. TIME OF DEATH: 3:15 AM
3b. DATE OF DEATH (Month, Day, Yr): November 30, 1989
4. SOCIAL SECURITY NUMBER: 305-30-4731
5a. AGE—Last Birthday (Years): 90
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): July 11, 1899
7. BIRTHPLACE (City and State or Foreign Country): Tolleston, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Rose Banaszak
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: Boat Building
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 118 E. 73rd Ave.
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Wilhelm Frank
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mathilda Krueger

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Rose Frank
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 E. 73rd Ave., Merrillville, Ind. 46410
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 4, 1989 Ridgelawn Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Henry J. Blake
22b. EMBALMER'S LICENSE NO.: FD01019406
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Eldon V. LaHayne
24b. LICENSE NUMBER (of Licensee): FD01041928
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LaHAYNE Funeral Home, Inc., FH83002885 5746 Hohman Ave., Hammond, Indiana 46320

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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. Cardio-pulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Arteriosclerotic Heart	years
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

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

DEC 1 1989

PART II. Other significant conditions. Conditions contributing to death but not resulting in the underlying cause given in Part I: Bleeding gastric ulcer

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):

Charles A. Johnson M.D. LAKE COUNTY HEALTH COMMISSIONER

Key# 15-28-48 W. 60Ft. of E. 300Ft of S. 200Ft. of SE1/4 of SW1/4 NW1/4 S15 T.35 R.8 .9 TAC

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: A. J. Krsek M.D.
29c. MEDICAL LICENSE NO.: 16778
29d. DATE SIGNED (Month, Day, Year): Nov. 30, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.J. KRSEK M.D. 101 Michigan Hobart, Ind. 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Charles A. Johnson M.D.
32. DATE FILED (Month, Day, Year): ~~Nov~~ DEC 1, 89

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:

FILED

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):

APR 10 1991

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

Anna N. Anton
AUDITOR LAKE COUNTY

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1