12cc

91021166

David J. Semis
Bx 88
11105 W 133rd Ave
Cedar Lake 46303

Local No. 3053-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: Carl MIDDLE: J. LAST: Halfman
2. SEX: M
3. DATE OF DEATH: 6-03-89
4. SOCIAL SECURITY NUMBER: 317-01-7555
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Month, Day, Year): May 12, 1919
7. BIRTHPLACE (City and State or Foreign Country): Lake Co., INDIANA
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: NA
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. Anthony Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): Furn TRAVIS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver
12b. KIND OF BUSINESS/INDUSTRY: Lake Co. Hwy. Dept.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Cedar Lake
13d. STREET AND NUMBER: 10930 West 141st Ave.
13e. INSIDE CITY LIMITS? (Yes or no): NO
13f. FARM: No
13g. ZIP CODE: 46303
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Joseph Halfman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Adler

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Furn Halfman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10930 West 141st Ave.
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Holy Name Cemetery
20c. LOCATION—City or Town, State: Cedar Lake, Ind.
21a. SIGNATURE OF FUNERAL DIRECTOR: William E. Burden
21b. LICENSE NUMBER (of Licensee): FD01007687
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home FH 8300246 12901 Wicker Ave., C.L., IN 46303

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: William A. Foto
23b. LICENSE NUMBER: Ind.
23c. DATE SIGNED (Month, Day, Year): 6/3/89

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 8:27 P.
25. DATE PRONOUNCED DEAD (Month, Day, Year): 6/3/89
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER?

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Uremia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. Polycystic disease kidney
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Dilated cardiomyopathy, severe peripheral neuropathy, ...

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

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ 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(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sampanta Boonjarern MD
29c. LICENSE NUMBER: 01027321
29d. DATE SIGNED (Month, Day, Year): 6/12/1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): SAMPANTA BOONJARERN M.D. 2068 LUCAS PKWY. LOWELL, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Carl A. Johnson MD
32. DATE FILED (Month, Day, Year): June 14, 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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)

600

SBH08-004 State Form 10110 (R/10-87) DEATH A/PD 1

01730

#6-68, 5/6/87, Pt 3, 6, 1st Delivery Cert.

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

STATE OF INDIANA, S.S. LAKE COUNTY
FILED FOR RECORD
MAY 3 ... 1991 ... 15 AM
ROBERT ... RECORDER

FILED
APR 30 1991
Anna M. Anton
LAKE COUNTY AUDITOR