

10 FA-4101 p1

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INDIANA STATE BOARD OF HEALTH

Return to: First American Title Insurance Company

CERTIFICATE OF DEATH

State No. 13307

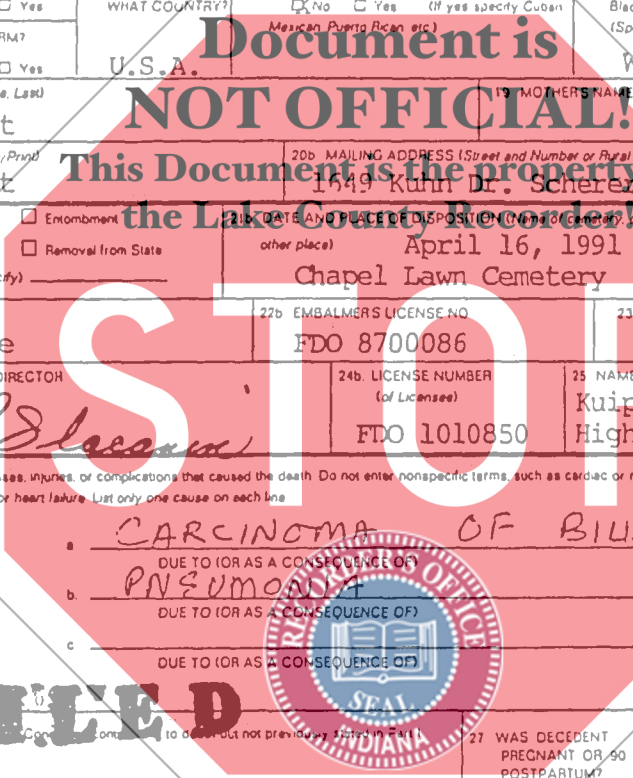
Local No. OS.41-91

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <b>Gus Kruit</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>10:00 AM</b>	3b DATE OF DEATH (Month Day Year) <b>April 13, 1991</b>
4 SOCIAL SECURITY NUMBER <b>392-28-3408</b>	5a AGE—Last Birthday (Years) <b>87</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>Mar. 24, 1904</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Netherlands</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) <b>The Medical Inn</b>		9c CITY/TOWN OR LOCATION OF DEATH <b>Munster</b>	9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Widowed</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Laborer</b>		12b KIND OF BUSINESS/INDUSTRY <b>Town Employee</b>
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Griffith</b>	13d STREET AND NUMBER <b>140 N. Dwiggins</b>	
13a ZIP CODE <b>46319</b>	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNK</b> College (14 or 5+) <b>UNK</b>		18 FATHER'S NAME (First Middle, Last) <b>William Kruit</b>		
19 MOTHER'S NAME (First Middle, Maiden Surname) <b>Unavailable</b>		20a INFORMANT'S NAME (Type/Print) <b>William Kruit</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1549 Kuhn Dr., Schererville, Indiana</b>		20c Relationship <b>Son</b>		
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 (If to cemetery, crematory, or other place) <b>April 16, 1991 Chapel Lawn Cemetery</b>		21c LOCATION—City or Town, State <b>Schererville, Indiana</b>
22a EMBALMER'S NAME <b>Raymond White</b>		22b EMBALMER'S LICENSE NO. <b>FDO 8700086</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>James Blosser</i>		24b LICENSE NUMBER (of Licensee) <b>FDO 1010850</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500</b>
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. <b>CARCINOMA OF BILIARY TRACT</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF) c. <b>DUE TO (OR AS A CONSEQUENCE OF)</b> Conditions, if any, which gave rise to the immediate cause, strong the underlying cause last <b>FILED</b> AUG 26 1991				
PART II. Other significant conditions contributing to death but not preceding it.		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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 my examination and/or investigation, in my opinion, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of my 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. <b>Paul H. Dinkel</b>		
29b SIGNATURE AND TITLE OF CERTIFIER <b>Paul H. Dinkel</b>		29c MEDICAL LICENSE NO. <b>0328574</b>		29d DATE SIGNED (Month Day Year) <b>4/15/91</b>
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DOSHI PARUL H. M.D. 7905, CALUMET AVE, MUNSTER IN 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams</i>				32 DATE FILED (Month Day Year)
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no) <b>LAKE COUNTY HEALTH DEPT</b>
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e 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.		

DECEASED  
PARENTS  
INFORMANT  
DISPOSITION  
CAUSE OF DEATH  
CORONER USE ONLY

Original Copy 11/2 Rt 3 All Rt 4 Bl 15 + Rt 5 Bl 5 # 26-135-446



Aug 30 9 22 AM  
ROBERT BOB FRELAND  
RECORDER  
LAKE COUNTY  
INDIANA  
FILED FOR RECORD

01526