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INDIANA STATE BOARD OF HEALTH

Ellendale 2nd Add to Highland
Lot 23, Block 7

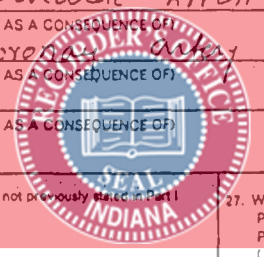
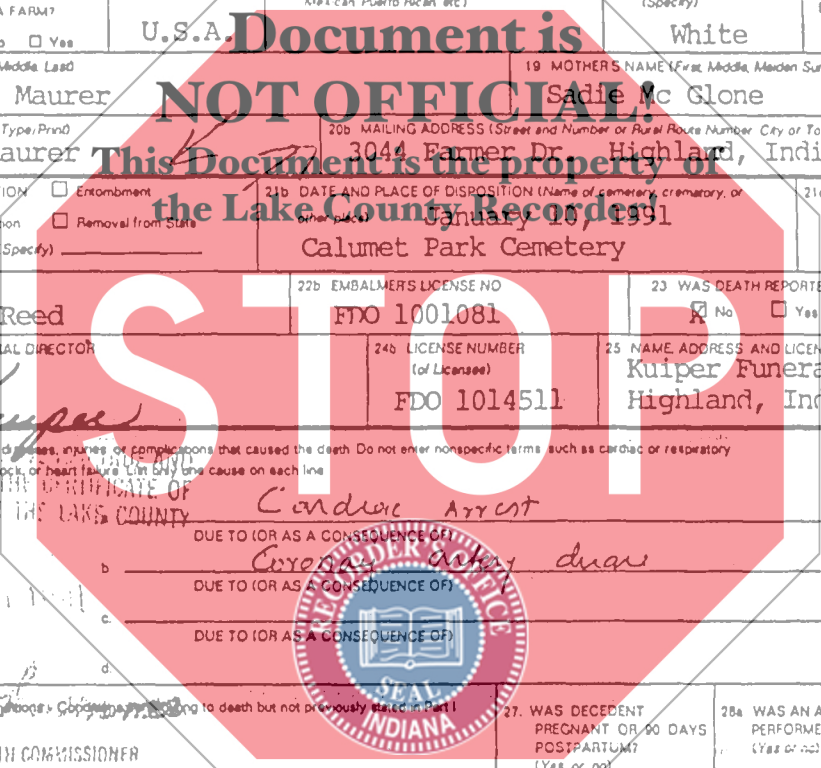
Local No. 58-91

CERTIFICATE OF DEATH

State No. Key # 27-314-23
Unit # 16

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle Last) William O. Maurer		2 SEX Male		3a TIME OF DEATH 10:20 P.M.		3b DATE OF DEATH (Month, Day, Year) January 7, 1991	
4 SOCIAL SECURITY NUMBER 317-09-7914		5a AGE—Last Birthday (Years) 74		5b UNDER 1 YEAR Months: Days:		5c UNDER 1 DAY Hours: Minutes:	
6a WAS DECEDENT A U.S. VETERAN? NO		6b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		6 DATE OF BIRTH (Mo, Day, Yr) Aug. 13, 1916			
7 BIRTHPLACE (City and State or Foreign Country) Mc Keesport, Pa.		8a PLACE OF DEATH (Check only one. See instructions): HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
9a FACILITY NAME (If not institution, give street and number) The Community Hospital				9b CITY, TOWN OR LOCATION OF DEATH Munster		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Virginia Pukoszek		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Heater Operator		12b KIND OF BUSINESS/INDUSTRY Steel Co.	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Highland		13d STREET AND NUMBER 3044 Farmer Dr.	
13e ZIP CODE 46322		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> 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) 12 College (1-4 or 5+)					
18 FATHER'S NAME (First, Middle, Last) William O. Maurer				19 MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Mc Glone			
20a INFORMANT'S NAME (Type/Print) Virginia Maurer				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3044 Farmer Dr. Highland, Indiana		20c Relationship Wife	
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 (Name of cemetery, crematory, or other place) January 7, 1991 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana			
22a EMBALMER'S NAME Ronald A. Reed		22b EMBALMER'S LICENSE NO. FDO 1001081		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of License) FDO 1014511		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500			
26 CAUSES 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. Cardiac Arrest Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) Approximate Interval Between Onset and Death							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO							
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO							
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 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 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 <i>[Signature]</i>				29c. MEDICAL LICENSE NO. 01035958		29d. DATE SIGNED (Month, Day, Year) 1-10-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 5500 Hohman Avenue, Hammond, IN 46320							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) January 10, 1991	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY FILED		34c. DESCRIBE HOW INJURY OCCURRED FILED	
34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) JAN 30 1992				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. None N. Antonio					



STATE OF INDIANA
LAKE COUNTY
FILED
JAN 30 1991
ROBERT BETHUNE

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY