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92006117

Local No. 58-91

# INDIANA STATE BOARD OF HEALTH
## CERTIFICATE OF DEATH

Ellendale 2nd Add to Highland Lot 23, Block 7 Key #27-314-23 Unit #16

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| 1 DECEASED—NAME (First, Middle, Last) | 2 SEX | 3a TIME OF DEATH | 3b DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|
| William O. Maurer | Male | 10:20 P M | January 7, 1991 |

| 4 SOCIAL SECURITY NUMBER | 5a AGE—Last Birthday (Years) | 5b UNDER 1 YEAR Months | Days | 5c UNDER 1 DAY Hours | Minutes | 6 DATE OF BIRTH (Mo. Day Yr.) | 7 BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|---|---|
| 317-09-7914 | 74 | | | | | Aug. 13, 1916 | Mc Keesport, Pa. |

| 8a WAS DECEDENT A U.S. VETERAN? | 8b YEAR LAST SERVED IN U.S. ARMED FORCES? | 9a PLACE OF DEATH (Check only one. See instructions.) |
|---|---|---|
| NO | N/A | HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b FACILITY NAME (If not institution, give street and number) | 9c CITY, TOWN OR LOCATION OF DEATH | 9d COUNTY OF DEATH |
|---|---|---|
| The Community Hospital | Munster | Lake |

| 10 MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Virginia Pukoszek | Heater Operator | Steel Co. |

| 13a RESIDENCE—STATE | 13b COUNTY | 13c. CITY, TOWN OR LOCATION | 13d STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Highland | 3044 Farmer Dr. |

| 13e ZIP CODE | 13f INSIDE CITY LIMITS | 13g ON A FARM? | 14 CITIZEN OF WHAT COUNTRY? | 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc) | 16 RACE—American Indian, Black, White, etc (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) |
|---|---|---|---|---|---|---|---|
| 46322 | ☐ No ☒ Yes | ☒ No ☐ Yes | U.S.A. | ☐ No ☐ Yes | White | 12 | |

**PARENTS**

| 18 FATHER'S NAME (First, Middle, Last) | 19 MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William O. Maurer | Sadie Mc Glone |

**INFORMANT**

| 20a INFORMANT'S NAME (Type/Print) | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c Relationship |
|---|---|---|
| Virginia Maurer | 3044 Farmer Dr. Highland, Indiana | Wife |

**DISPOSITION**

| 21a METHOD OF DISPOSITION | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c LOCATION—City or Town, State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) | January 10, 1991 Calumet Park Cemetery | Merrillville, Indiana |

| 22a EMBALMER'S NAME | 22b EMBALMER'S LICENSE NO | 23 WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Ronald A. Reed | FDO 1001081 | ☒ No ☐ Yes |

| 24a SIGNATURE OF FUNERAL DIRECTOR | 24b LICENSE NUMBER (of Licensee) | 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| A Kuiper | FDO 1014511 | Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500 |

**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. Enter only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Coronary artery disease

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

PART II. Other significant conditions contributing to death but not previously stated in Part I

LAKE COUNTY HEALTH COMMISSIONER

| 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) |
|---|---|---|
| NO | NO | |

**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

| 29b SIGNATURE AND TITLE OF CERTIFIER | 29c MEDICAL LICENSE NO. | 29d DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R S Thagard | 01035953 | 1-10-91 |

**HEALTH OFFICER**

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: Robert Guthrie D.O.

32. DATE FILED (Month, Day, Year): January 10, 1991

**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)

JAN 30 1992

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

Anna N. Antone Lake County

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

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