02006509

Local No. 1060

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jan 31, 1992 — [signature] M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1 DECEASED—NAME (First Middle Last): MAXWELL C. WERNERSBACH
- 2 SEX: MALE
- 3a TIME OF DEATH: 4:07p M
- 3b DATE OF DEATH (Month Day Yr): DECEMBER 12,1990
- 4 SOCIAL SECURITY NUMBER: 303-16-4894
- 5a AGE—Last Birthday (Years): 75
- 5b UNDER 1 YEAR (Months, Days):
- 5c UNDER 1 DAY (Hours, Minutes):
- 6 DATE OF BIRTH (Mo Day Yr): MAY 25,1915
- 7 BIRTHPLACE (City and State or Foreign Country): TERRE HAUTE,INDIANA
- 8a WAS DECEDENT A US VETERAN?: NO
- 8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
- 9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
- 9b FACILITY NAME (If not institution, give street and number): 3019 165TH STREET
- 9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND
- 9d COUNTY OF DEATH: LAKE
- 10 MARITAL STATUS (Specify): MARRIED
- 11 SURVIVING SPOUSE (If wife give maiden name): ANN KUZEMKA
- 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MACHINIST
- 12b KIND OF BUSINESS/INDUSTRY: HARBISON-WALKER
- 13a RESIDENCE—STATE: INDIANA
- 13b COUNTY: LAKE
- 13c CITY, TOWN OR LOCATION: HAMMOND
- 13d STREET AND NUMBER: 3019 165TH STREET
- 13e ZIP CODE: 46323
- 13f INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g ON A FARM?: ☒ No ☐ Yes
- 14 CITIZEN OF WHAT COUNTRY?: USA
- 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
- 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+):

PARENTS

- 18 FATHER'S NAME (First Middle Last): MAX JOHN WERNERSBACH
- 19 MOTHER'S NAME (First Middle Maiden Surname): FLORENCE RABS

INFORMANT

- 20a INFORMANT'S NAME (Type/Print): MRS. ANN WERNERSBACH
- 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3019 165TH STREET HAMMOND, INDIANA 46323
- 20c Relationship: WIFE

DISPOSITION

- 21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
- 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): CHAPEL LAWN MEMORIAL GARDENS DECEMBER 15,1990
- 21c LOCATION—City or Town, State: SCHERERVILLE, INDIANA
- 22a EMBALMER'S NAME: ROD A. IVY
- 22b EMBALMER'S LICENSE NO: FD01018769
- 23 WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
- 24a SIGNATURE OF FUNERAL DIRECTOR: Rod A. Ivy
- 24b LICENSE NUMBER (of Licensee): FD01018769
- 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: C.J. HUBER FUNERAL HOME 722 165TH ST. HAMMOND, INDIANA 46324 FDH3002851

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. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF):

b. Acute Myocardial Infarction

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.

FILED JAN 31 1992 — [signature] AUDITOR LAKE COUNTY

PART II Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in Part I

- 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): N/A

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: [signature] George MD
- 29c MEDICAL LICENSE NO: 31470
- 29d DATE SIGNED (Month Day Year): December 13, 1990
- 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN GEORGE M.D. 7905 CALUMET AV. MUNSTER, INDIANA 46321

HEALTH OFFICER

- 31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
- 32 DATE FILED (Month Day Year): DEC 14 1990

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

01651

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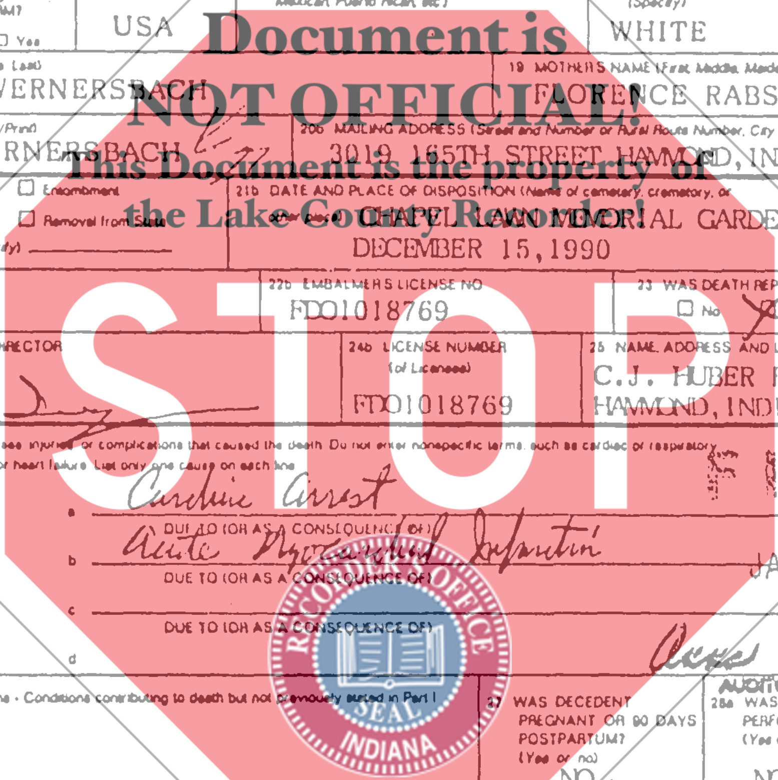
Lay # 36-264-7 Turner Wright Park L. 7 Bl. 17 W. 15 ft L. 8 Bl. 17

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