

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

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92007702

ARKANSAS DEPARTMENT OF HEALTH Division of Vital Records CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) Basil John Lorenz; 2. SEX Male; 3. DATE OF DEATH (Month, Day, Year) May 7, 1989; 4. SOCIAL SECURITY NUMBER 311-03-6908; 5a. AGE -- Last Birthday (Years) 71; 5b. UNDER 1 YEAR Months; 5c. UNDER 1 DAY Hours; 6. DATE OF BIRTH (Month, Day, Year) Dec. 31, 1917; 7. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois; 8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) Yes; 9a. PLACE OF DEATH (Check only one) RESIDENCE; 9b. FACILITY NAME (If not institution, give street and number) Rt. 1, Box 250; 9c. CITY, TOWN, OR LOCATION OF DEATH Lakeview; 9d. COUNTY OF DEATH Baxter; 10. MARITAL STATUS -- Married; 11. SURVIVING SPOUSE (If wife, give maiden name) Alice M. Schreiber; 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Safety Manager; 12b. KIND OF BUSINESS/INDUSTRY Public Utilities; 13a. RESIDENCE -- STATE Arkansas; 13b. COUNTY Baxter; 13c. CITY, TOWN, OR LOCATION Lakeview; 13d. STREET AND NUMBER Rt. 1, Box 250; 13e. INSIDE CITY LIMITS? (Yes or No) Yes; 13f. ZIP CODE 72642; 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) No; 15. RACE -- American Indian, (Black, White, etc. (Specify) White; 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4; 17. FATHER'S NAME (First, Middle, Last) John --- Lorenz; 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie --- Wollenberg; 19a. INFORMANT'S NAME (Type/Print) Alice M. Lorenz; 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 250, Lakeview, Arkansas 72642; 20a. METHOD OF DISPOSITION Burial; 20b. DATE OF DISPOSITION (Month, Day, Year) May 12, 1989; 20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Concordia Cemetery; 20d. LOCATION -- City or Town, State Hammond, Indiana; 21a. SIGNATURE OF EMBALMER [Signature]; 21b. LICENSE NUMBER 1687; 22a. NAME AND ADDRESS OF FUNERAL HOME Roller Funeral Home; 22b. LICENSE NUMBER 33; 23. 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. REGISTERS CARCINOMA of prostate; b. This Document is the property of the Lake County Recorder!; c. DUE TO (OR AS A CONSEQUENCE OF); d. DUE TO (OR AS A CONSEQUENCE OF); PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.; 24. WAS AN AUTOPSY PERFORMED? (Yes or No) No; 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No; 26. MANNER OF DEATH Natural; 27. DATE OF INJURY (Month, Day, Year); 28. TIME OF INJURY M; 29. INJURY AT WORK? (Yes or No); 30. DESCRIBE HOW INJURY OCCURRED; 31. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify); 32. LOCATION (Street and Number or Rural Route Number, City or Town, State); 33. TIME OF DEATH 9:00 AM; 34. DATE PRONOUNCED DEAD (Month, Day, Year) May 7, 1989; 35. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) No; 36. MEDICAL EXAMINER or CORONER Only 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. Signature and Title; 37. DATE SIGNED (Month, Day, Year); 38. CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. Signature and Title; 39. DATE SIGNED (Month, Day, Year) May 11, 1989; 40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Max Cheney, M.D., 353 8th., Mtn. Home, arkansas 72653; 41. REGISTRAR'S SIGNATURE [Signature]; 42. DATE FILED (Month, Day, Year) FEB 5 1989

DECEDENT NAME OF DECEDENT For use by physician or institution SEE INSTRUCTIONS ON OTHER SIDE

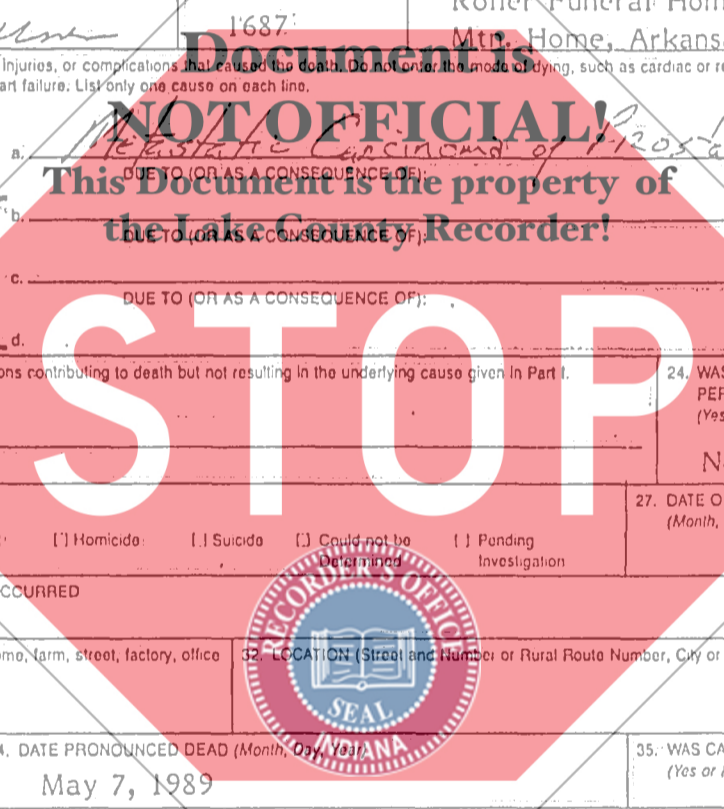
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

REGISTRAR



STATE OF ARKANSAS FILED FEB 5 1989

FILED FEB 5 1989

THIS IS A CERTIFIED COPY OF AN ORIGINAL DOCUMENT

THIS IS TO CERTIFY, That the above is an exact reproduction of the original certificate, which is in my possession this date and of which I have the authority to issue under Act 120 of 1981. IN TESTIMONY WHEREOF, witness my hand and seal of office at

Calumet Blvd. All Rt 6 Bl 5 S. 29th Rt 7 Bl 5 #32-101-7

MAY 16 1989

Date

William M. Hughes County Registrar

600 ca