INDIANA STATE BOARD OF HEALTH

Local No. 165-91 **92010195** CERTIFICATE OF DEATH 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)
Arthur	F.	Jaenke	Male	10:30A M	May 30, 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)
312-09-1462	86			MAR 8, 1905	Chicago, IL

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
St. Anthony Medical Center	Crown Point	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	Alice Shawcroft	Steel Roller	Inland Steel

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	St. John	11411 W. 93rd Avenue

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+)
46373	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	11	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Herman Jaenke	Louis Zacoby

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
Alice Jaenke	11411 W. 93rd Avenue, St. John, IN 46373	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 ☐ Donation ☐ Other (Specify): ☐ Entombment ☐ Removal from State	JUN 3, 1991 Chapel Hill Memorial Gardens	Schererville, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Marty Andersen	FD01005205	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Robert P. Geisen	FD01000328	FD83001253 Geisen Funeral Home, Inc. 109 N. East St, Crown Point, IN 46307

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. Myocardial degeneration	yrs
DUE TO (OR AS A CONSEQUENCE OF):	b. Arteriosclerotic & Heart disease	
DUE TO (OR AS A CONSEQUENCE OF):	c.	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. FEB 19 1992 DUE TO (OR AS A CONSEQUENCE OF):	d.	

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
FEB		No

LAKE COUNTY HEALTH COMMISSIONER

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) 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)
Mary D. Carroll, M.D.	16029	6/3/91

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print)	31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Mary D. Carroll M. D. 124 N. Main Street, Crown Point, IN 46307	Alexander S. Williams, M.D.	June 5, 1991

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

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

00971

Key # 1-61-3 & 20 Pt. S. 1/2 NE 1/4 S. 17 T. 33 R. 9 79.83A Key # 12-14-10, 11, 13 + 73 Keilman's 2nd Add. L 10 To L 13

Wm F Carroll 1017 Main Cr Pt 46307