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

Feb. 3, 1992 — Date Issued — Franklin D. Demus M.D. — Hammond Health Commissioner

Local No. 973 **92010736**

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Item	Entry
1 DECEASED—NAME (First Middle Last)	Richard R. Held Sr.
2 SEX	Male
3a TIME OF DEATH	1:05 a.M.
3b DATE OF DEATH (Month Day Yr)	November 29, 1991
4 SOCIAL SECURITY NUMBER	311-36-3909
5a AGE—Last Birthday (Years)	55
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	May 8, 1936
7 BIRTHPLACE (City and State or Foreign Country)	Chicago Heights, Illinois
8a WAS DECEDENT A US VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1960
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	St. Margaret Hospital
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)	Betty Gootee
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Truck Mechanic
12b KIND OF BUSINESS/INDUSTRY	Trucking Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	4037 Torrence Avenue
13e ZIP CODE	46327
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Item	Entry
18 FATHER'S NAME (First Middle Last)	William Held
19 MOTHER'S NAME (First Middle Maiden Surname)	Marie Grau

INFORMANT

Item	Entry
20a INFORMANT'S NAME (Type/Print)	Betty Held
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4037 Torrence Avenue, Hammond, In 46327
20c Relationship	Wife

DISPOSITION

Item	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 2, 1991 Memory Lane Cemetery
21c LOCATION—City or Town, State	Schererville, Indiana
22a EMBALMER'S NAME	Keith D. Anthony
22b EMBALMER'S LICENSE NO	01011911
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Keith D Anthony
24b LICENSE NUMBER (of Licensee)	01011911
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, In 46327

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Carcinoma of the rectum c metastasis to liver	months
DUE TO (OR AS A CONSEQUENCE OF) b		
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 resulting in the underlying cause given in Part I

Item	Entry
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)	NO

CERTIFIER

29a CERTIFIER (Check only one)

[X] 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

Item	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	C A Foreit D.O.
29c MEDICAL LICENSE NO	161
29d DATE SIGNED (Month, Day, Year)	November 29, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	C. A. Foreit, D.O. 3831 Hohman Avenue, Hammond, Indiana 46327

HEALTH OFFICER

Item	Entry
31 HEALTH OFFICER'S SIGNATURE	Franklin D. Demus M.D.
32 DATE FILED (Month, Day, Year)	DECEMBER 3, 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)

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

00822 600 / W

#34-37-38 Hammond Steel City Add. S.18' Lt 37 N30' Lt 38 Bk 4

FILED FEB 16 1992 — Auditor Lake County

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