92010954

Local No. 1229-91

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): William E. Stolte Jr.
2. SEX: Male
3a. TIME OF DEATH: 5:00PM
3b. DATE OF DEATH (Month, Day, Yr): June 9, 1991
4. SOCIAL SECURITY NUMBER: 304-38-9678
5a. AGE—Last Birthday (Years): 53
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): OCT 14, 1937
7. BIRTHPLACE (City and State or Foreign Country): Griffith, IN
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Anthony Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Diana Burns
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Automation Tender
12b. KIND OF BUSINESS/INDUSTRY: Ford Stamping Plant
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 403 Church Street
13e. ZIP CODE: 46307
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?: [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): William E. Stolte Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Louise [illegible] Reder

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Diana Stolte
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 Church Street, Crown Point, IN 46307
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JUN 12 1991 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Robert P. Geisen
22b. EMBALMER'S LICENSE NO.: FD01000328
23. WAS DEATH REPORTED TO CORONER?: [ ] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert P. Geisen
24b. LICENSE NUMBER (of Licensee): FD01000328
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 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.

Immediate cause (Final disease or condition resulting in death): a. Ventricular arrythmia

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF): severe Ischemic heart disea

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death:

FILED

THIS COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY [illegible]

FEB 24 1992

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

FEB 07 1992

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

AUDITOR LAKE COUNTY

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Vidyadhar Gandra M. D.
29c. MEDICAL LICENSE NO.: 29999
29d. DATE SIGNED (Month, Day, Year): 6-11-91

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Vidyadhar Gandra M. D., 297 Franciscan Drive, Crown Point, IN 46307
31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): JUN 11 1991

CORONER USE ONLY

33. MANNER OF DEATH: [X] 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.:

01219

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