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INDIANA STATE BOARD OF HEALTH

Local No. 12-16-92

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): William ~~A.~~ H. Gebert

2 SEX: Male

3a TIME OF DEATH: 9:00 A M

3b DATE OF DEATH (Month, Day, Yr.): June 4, 1992

4 SOCIAL SECURITY NUMBER: 340-01-3282

5a AGE—Last Birthday (Years): 84

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Month, Day, Year): Aug. 9, ~~1908~~ 1907

7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois

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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number): 521 North Lindberg

9c CITY, TOWN, OR LOCATION OF DEATH: Griffith

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Mildred L. Polkinghon

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Plumber

12b KIND OF BUSINESS/INDUSTRY: Plumbing

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Griffith

13d STREET AND NUMBER: 521 North Lindberg

13e ZIP CODE: 46319

13f INSIDE CITY LIMITS: ☐ No ☒ Yes

13g ON A FARM?: ☒ No ☐ Yes

14. CITIZEN OF WHAT COUNTRY?: U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): William Gebert

19 MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Nitsche

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mildred L. Gebert

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 521 N. Lindberg Griffith, In 46319

20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 6, 1992 Chapel Lawn Memorial Gardens

21c. LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: Edgar C. Gleim

22b EMBALMER'S LICENSE NO.: FD01016173

23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: C A

24b. LICENSE NUMBER (of Licensee): FD01014511

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Road Highland, Indiana 46322 FH83007500

CAUSE OF DEATH

26. PART I. Enter the disease, 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. Respiratory Failure

DUE TO (OR AS A CONSEQUENCE OF) b. Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF) c.

DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

FILED JUN 10 1992

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPT.

Anna M. Acton AUDITOR LAKE COUNTY

PART II. Other significant conditions. Conditions that contributed to death but not necessarily related in Part I.

Diabetes Mellitus, Cardiac Arrhythmia, Chronic renal failure

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no

28. WAS AN AUTOPSY PERFORMED? (Yes or no):

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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: Steven A. Corse D.O.

29c. MEDICAL LICENSE NO.: 02000686

29d. DATE SIGNED (Month, Day, Year): June 4, 1992

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Steven A. Corse, D.O. 3100 45th Street Highland, IN 46322

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.

32. DATE FILED (Month, Day, Year): June 5, 1992

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.

00708

REV 26-195-26 PARK MANOR, 4TH ADD TO GRIFFITH LOT 36 BLOCK 2

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