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INDIANA STATE BOARD OF HEALTH

Local No. .... 1664-92

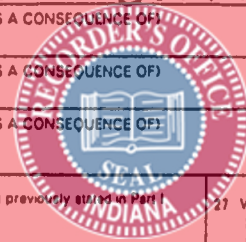
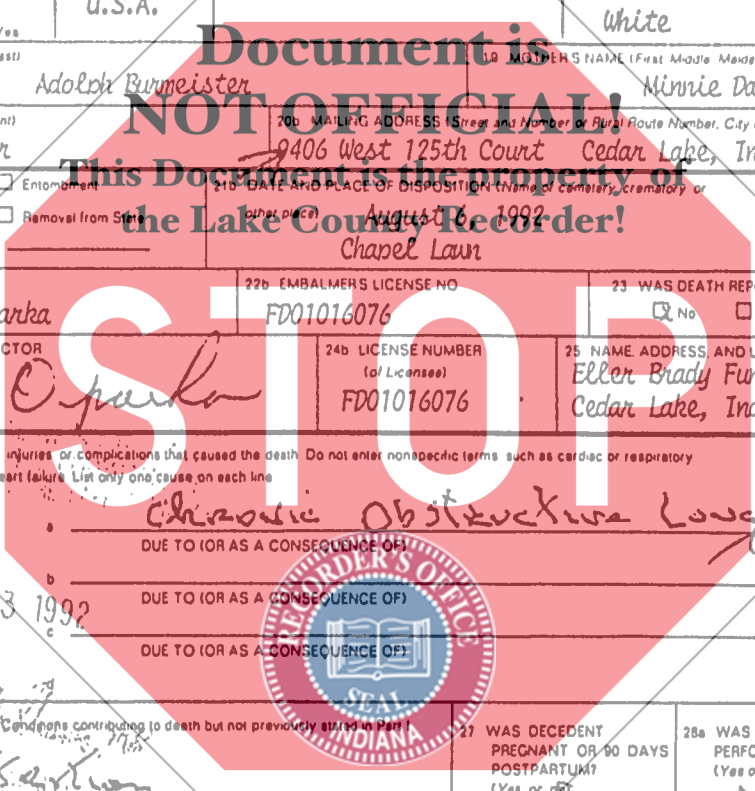
CERTIFICATE OF DEATH

State No. ....

Singleton's Oak 11:11 Add Lot 10; Key #24-139-9, Unit # 30

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <i>Martin J. Burmeister</i>		2 SEX <i>Male</i>	3a TIME OF DEATH <i>2:00 A.</i>	3b DATE OF DEATH (Month Day Year) <i>August 4, 1992</i>
4 SOCIAL SECURITY NUMBER <i>315-12-7311-A</i>	5a AGE—Last Birthday (Years) <i>81</i>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <i>August 24, 1910</i>
7 BIRTHPLACE (City and State or Foreign Country) <i>Chebanse, Illinois</i>	8a WAS DECEASED A U.S. VETERAN? <i>No</i>	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution give street and number) <i>St. Anthony's Nursing Home</i>		9c CITY TOWN OR LOCATION OF DEATH <i>Crown Point</i>	9d COUNTY OF DEATH <i>Lake</i>	
10 MARITAL STATUS (Specify) <i>Married</i>	11 SURVIVING SPOUSE (If wife give maiden name) <i>Florence Fleischmen</i>	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <i>Sheet Metal</i>	12b KIND OF BUSINESS/INDUSTRY <i>Glass Service Company</i>	
13a RESIDENCE—STATE <i>Indiana</i>	13b COUNTY <i>Lake</i>	13c CITY TOWN OR LOCATION <i>Cedar Lake</i>	13d STREET AND NUMBER <i>9406 West 125th Court</i>	
13e ZIP CODE <i>46303</i>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	15 WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <i>White</i>
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (13 or 16+)		18 FATHER'S NAME (First Middle Last) <i>Adolph Burmeister</i>		
19 MOTHER'S NAME (First Middle Maiden Surname) <i>Ninnie Dau</i>		20a INFORMANT'S NAME (Type Print) <i>Florence Burmeister</i>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9406 West 125th Court Cedar Lake, Indiana 46303</i>		20c Relationship <i>wife</i>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>August 6, 1992 Chapel Lawn</i>		21c LOCATION—City, Town, State <i>Schererville, Indiana</i>
22a EMBALMER'S NAME <i>Fred Oparka</i>		22b EMBALMER'S LICENSE NO. <i>FD01016076</i>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Fred Oparka</i>		24b LICENSE NUMBER (of Licensee) <i>FD01016076</i>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <i>Eller Brady Funeral Home, Inc. FH83000825 Cedar Lake, Indiana 46303</i>	
26 PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Chronic Obstructive Lung Disease</i> DUE TO (OR AS A CONSEQUENCE OF) Approximate Interval Between Onset and Death <i>3 Mos.</i>		27 WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) <i>No</i>		
28a WAS AN AUTOPSY PERFORMED? (Yes or No) <i>No</i>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) <input checked="" type="checkbox"/>		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>W. A. Misch MD</i>		
29c MEDICAL LICENSE NO. <i>01015490</i>		29d DATE SIGNED (Month, Day, Year) <i>8/5/92</i>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) <i>W. A. Misch MD 13963 Morse St, Cedar Lake, IN</i>				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>				32 DATE FILED (Month, Day, Year) <i>August 5, 1992</i>
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>NOV 9 1992</i>		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, or pedestrian <i>600</i>		



DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY