93002713

INDIANA STATE BOARD OF HEALTH

Local No. .....

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Carson Hacker
2 SEX: Male
3a TIME OF DEATH: 3:30 A.M.
3b DATE OF DEATH (Month Day Year): December 8, 1992
4 SOCIAL SECURITY NUMBER: 401-28-2895
5a AGE—Last Birthday (Years): 72
5b UNDER 1 YEAR (Months, Days)
5c UNDER 1 DAY (Hours, Minutes)
6 DATE OF BIRTH (Month Day Year): May 27, 1920
7 BIRTHPLACE (City and State or Foreign Country): Manchester, Kentucky
8a WAS DECEDENT A U.S. VETERAN? YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946
8c PLACE OF DEATH (Check only one—See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing home ☐ Other (Specify) ☐ Residence
9a FACILITY NAME (If not institution give street and number): St. Catherine Hospital
9b CITY, TOWN OR LOCATION OF DEATH: East Chicago
9c COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Ann Thompson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Electrical Foreman
12b KIND OF BUSINESS/INDUSTRY: Steel Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Cedar Lake
13d STREET AND NUMBER: 11701 W. 119th Ct.
13e ZIP CODE: 46303
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: 12

PARENTS

18 FATHER'S NAME (First Middle Last): Larkin Hacker
19 MOTHER'S NAME (First Middle Maiden Surname): Eva Burnette

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ann hacker
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11701 W. 119th Ct. Cedar Lake, Indiana
20c RELATIONSHIP: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 11, 1992 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Edgar Gleim
22b EMBALMER'S LICENSE NO: FDO 1016173
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: W. F. Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH-300-7500

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. ATHEROSCLEROTIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF): b. V.F. VENTRICULAR FIBRILLATION
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: a. 15 YEARS; b. 10 MINUTES

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: METASTATIC CANCER OF THE LUNG

27 WAS DECEDENT PREGNANT OR WITHIN 90 DAYS POSTPARTUM? (Yes or no): N/A
28a WAS AN AUTOPSY PERFORMED? (Yes or no): 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: M. C. Garcia
29c MEDICAL LICENSE NO: 25594 IN
29d DATE SIGNED (Month Day Year): 12-08-92

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Miguel A. Garcia, M.D. 4320 Fir Street Suite 410 East Chicago, IN 46312
31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month Day Year):

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: FILED
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):
JAN 12 1993 6:00
34g DATE PRONOUNCED DEAD (Month Day Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.:
Anna N. Antone
AUDITOR LAKE COUNTY
06671

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