

LTIC 54875 5cc's

93014253

INDIANA STATE BOARD OF HEALTH

Local No. (951-90)

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS INFORMANT

DISPOSITION

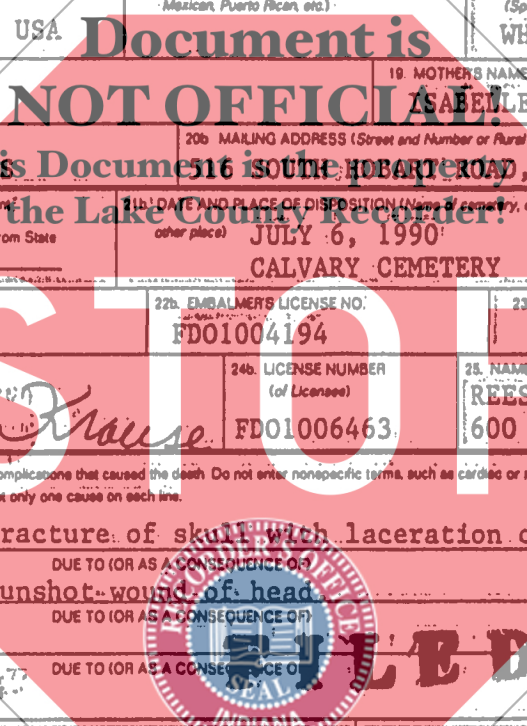
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) HAROLD J. DAGENAIS		2. SEX MALE	3a. TIME OF DEATH 11:59A	3b. DATE OF DEATH (Month, Day, Yr) JULY 1, 1990	
4. SOCIAL SECURITY NUMBER 328-12-1141	5a. AGE—Last Birthday (Years) 67	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo, Day, Yr) SEPT 26, 1922	
7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS	8a. WAS DECEDENT A U.S. VETERAN? YES				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient; <input type="checkbox"/> ER/Outpatient; <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home; <input type="checkbox"/> Other (Specify): <input checked="" type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) 516 SOUTH HOBART ROAD		9b. CITY, TOWN, OR LOCATION OF DEATH HOBART	9c. COUNTY OF DEATH LAKE COUNTY		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) GERALDINE FAY	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) IRON WORKER		12b. KIND OF BUSINESS/INDUSTRY LOCAL 395	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HOBART	13d. STREET AND NUMBER 516 SOUTH HOBART ROAD		
13e. ZIP CODE 46342	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? USA	15. WAS DECEDENT 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) WHITE	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5 +)			
18. FATHER'S NAME (First, Middle, Last) (UNAVAILABLE) WILLS		19. MOTHER'S NAME (First, Middle, Maiden Surname) ISABELLE STARRETT			
20a. INFORMANT'S NAME (Type/Print) GERALDINE A. DAGENAIS		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 SOUTH HOBART ROAD, HOBART, IN 46342		20c. Relationship SPOUSE	
21a. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Entombment; <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) JULY 6, 1990 CALVARY CEMETERY		21c. LOCATION—City or Town, State PORTAGE, INDIANA	
22a. EMBALMER'S NAME JAMES W. GHOLSTON		22b. EMBALMER'S LICENSE NO. FDO1004194		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licenses) FDO1006463		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOMES, INC. FH83003069 600 WEST RIDGE RD, HOBART, IN 46342	
26. CAUSE OF DEATH (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) B 05 1993 CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE <i>[Signature]</i> a. Fracture of skull with laceration of brain. DUE TO (OR AS A CONSEQUENCE OF) b. Gunshot wound of head. DUE TO (OR AS A CONSEQUENCE OF) c. ... DUE TO (OR AS A CONSEQUENCE OF) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT PREVIOUSLY LISTED FEB 2 1993					
28a. WAS AN ALCOHOL TEST PERFORMED? (Yes or no) YES		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) YES			
29a. CERTIFIER (Check only one): <input 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 checked="" 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. MEDICAL LICENSE NO. 16120			
29c. DATE SIGNED (Month, Day, Year) September 24, 1990		29d. DATE SIGNED (Month, Day, Year) SEP 25, 1990			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DANIEL THOMAS, MD, LAKE COUNTY CORONER, 2293 NORTH MAIN STREET, CROWN POINT, IN 46307					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) SEP 25, 1990	
33. MANNER OF DEATH <input type="checkbox"/> Natural; <input type="checkbox"/> Pending Investigation; <input type="checkbox"/> Accident; <input checked="" type="checkbox"/> Suicide; <input type="checkbox"/> Could not be Determined; <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) July 1, 1990	34b. TIME OF INJURY Unknown	34c. INJURY AT WORK? (Yes or no) No	34d. DESCRIBE HOW INJURY OCCURRED Gunshot wound
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) Home		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 516 South Hobart Road Hobart, Indiana			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) July 1, 1990		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. No			



SAMUEL ORLICH RECORDED

FILED FOR RECORD OF INDIANA LAKE COUNTY

#17-155-5161
Wm. Baker East Side 8.5.16.7.9

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