93014310

Local No. 130

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND CORRECT COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Feb 17, 1993 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

| Field | Entry |
|---|---|
| 1 DECEASED—NAME (First Middle Last) | GERALD E. CRAGGS |
| 2 SEX | MALE |
| 3a TIME OF DEATH | 4:16 PM |
| 3b DATE OF DEATH (Month Day Yr) | FEBRUARY 10, 1993 |
| 4 SOCIAL SECURITY NUMBER | 705-16-3514 |
| 5a AGE—Last Birthday (Years) | 73 |
| 5b UNDER 1 YEAR (Months / Days) | |
| 5c UNDER 1 DAY (Hours / Minutes) | |
| 6 DATE OF BIRTH (Mo Day Yr) | March 1, 1919 |
| 7 BIRTHPLACE (City and State or Foreign Country) | Oakford, IL |
| 8a WAS DECEDENT A US VETERAN? | Yes |
| 8b YEAR LAST SERVED IN US ARMED FORCES? | 1945 |
| 9a PLACE OF DEATH (Check only one. See instructions) | HOSPITAL: ☐ Inpatient ☐ ER/Outpatient XX DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify) |
| 9b FACILITY NAME (If not institution, give street and number) | ST. MARGARET HOSPITAL |
| 9c CITY, TOWN OR LOCATION OF DEATH | HAMMOND |
| 9d COUNTY OF DEATH | LAKE |
| 10 MARITAL STATUS (Specify) | Married |
| 11 SURVIVING SPOUSE (If wife, give maiden name) | ALberta Koppelman |
| 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | Stationary Engineer |
| 12b KIND OF BUSINESS/INDUSTRY | Amoco Oil |
| 13a RESIDENCE—STATE | IN |
| 13b COUNTY | Lake |
| 13c CITY, TOWN OR LOCATION | Hammond |
| 13d STREET AND NUMBER | 5440 White Oak |
| 13e ZIP CODE | 46320 |
| 13f INSIDE CITY LIMITS | ☐ No X Yes |
| 13g ON A FARM? | X No ☐ Yes |
| 14 CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.) | XX No ☐ Yes |
| 16 RACE—American Indian, Black, White, etc. (Specify) | White |
| 17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) | 12 |

**PARENTS**

| Field | Entry |
|---|---|
| 18 FATHER'S NAME (First Middle Last) | Clayton Craggs |
| 19 MOTHER'S NAME (First Middle Maiden Surname) | Clara Avery |

**INFORMANT**

| Field | Entry |
|---|---|
| 20a INFORMANT'S NAME (Type/Print) | Alberta Craggs |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 5440 White Oak Hammond, IN 46320 |
| 20c Relationship | Wife |

**DISPOSITION**

| Field | Entry |
|---|---|
| 21a METHOD OF DISPOSITION | XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) |
| 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | February 13, 1993 Chapel Lawn Memorial Gardens |
| 21c LOCATION—City or Town, State | Schererville, IN |
| 22a EMBALMER'S NAME | Kevin W. Kish |
| 22b EMBALMER'S LICENSE NO. | 1021590 |
| 23 WAS DEATH REPORTED TO CORONER? | X No ☐ Yes |
| 24a SIGNATURE OF FUNERAL DIRECTOR | Thomas J. Burns |
| 24b LICENSE NUMBER (of Licensee) | 1045184 |
| 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME | Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321 |

**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. Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF)

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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

Approximate Interval Between Onset and Death

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

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

**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.

| Field | Entry |
|---|---|
| 29b SIGNATURE AND TITLE OF CERTIFIER | [signature] |
| 29c MEDICAL LICENSE NO | 31764 |
| 29d DATE SIGNED (Month, Day, Year) | FEBRUARY 16, 1993 |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) | DR. S. N. MAKAM, M. D. 9122 COLUMBIA AVENUE MUNSTER, INDIANA 46321 |

**HEALTH OFFICER**

| Field | Entry |
|---|---|
| 31 HEALTH OFFICER'S SIGNATURE | Franklin I. Espemudia M.D. |
| 32 DATE FILED (Month, Day, Year) | February 17, 1993 |

FILED

**CORONER USE ONLY**

| Field | Entry |
|---|---|
| 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. | |

MAR 4 1993

Agnes N. Antone — AUDITOR LAKE COUNTY

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00306

STATE OF INDIANA S.S. NO. LAKE COUNTY FILED FOR RECORD

MAR 4 2 32 PM '93

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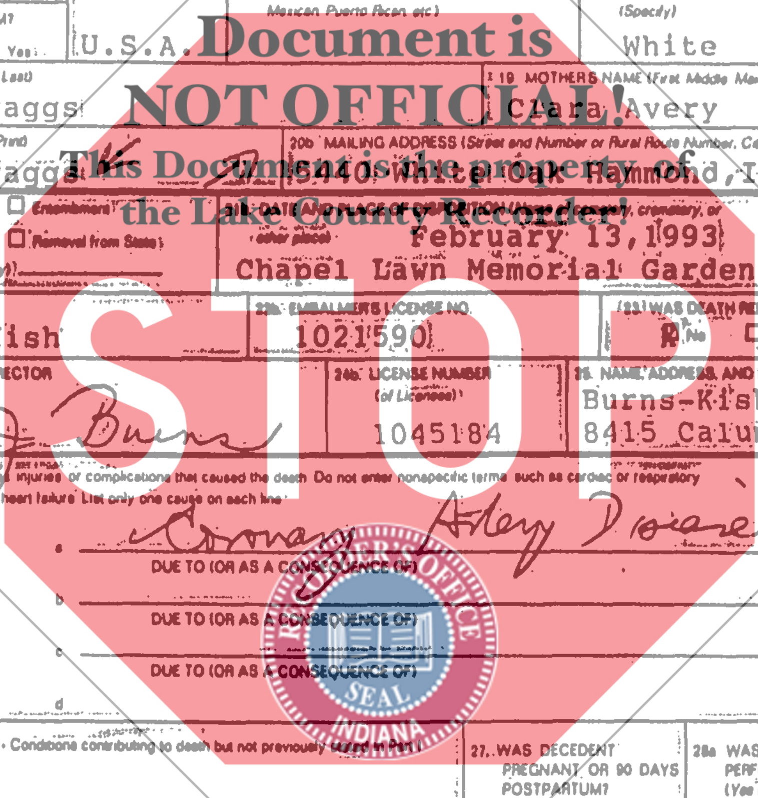
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