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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0197-93

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

KEY 7-38-3 W 3 W 2 NWNE S.25 T34 R9

DECEDENT

1 DECEASED—NAME (First Middle Last): ERNEST A HAUSMANN
2 SEX: MALE
3a TIME OF DEATH: 11:47 PM
3b DATE OF DEATH (Month, Day, Yr): JANUARY 24, 1993
4 SOCIAL SECURITY NUMBER: 313-07-7365
5a AGE—Last Birthday (Years): 76
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): OCT. 4, 1916
7 BIRTHPLACE (City and State or Foreign Country): GARY IN
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 ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 5517 W. 133rd
9c CITY, TOWN OR LOCATION OF DEATH: CROWN POINT
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): ANGELINE LINCH
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): AUTO SALVAGE REPAIR
12b KIND OF BUSINESS/INDUSTRY: FORD MOTOR COMPANY
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: CROWN POINT
13d STREET AND NUMBER: 5517 W. 133rd
13e ZIP CODE: 46307
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): 8; College (1-4 or 5+):

PARENTS

18 FATHERS NAME (First Middle Last): ALLEN HAUSMANN
19 MOTHERS NAME (First Middle Maiden Surname): CAROLINE MARIE STROH

INFORMANT

20a INFORMANT'S NAME (Type/Print): ANGELINE HAUSMANN
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5517 WEST 133rd, CROWN POINT, IN 46307
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): JANUARY 27, 1993 NORTHWEST INDIANA CREMATION SERV.
21c LOCATION—City or Town, State: CROWN POINT INDIANA
22a EMBALMER'S NAME: NOT NECESSARY
22b EMBALMER'S LICENSE NO.:
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Clarence D Burns
24b LICENSE NUMBER (of Licensee): 10103890
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445

THIS CERTIFICATE MUST BE COMPLETED AND FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. LYMPHOMA WITH BRAIN INVOLVEMENT — 2 years
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

JAN 29 1993
LAKE COUNTY HEALTH COMMISSIONER

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): NO
28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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:
29c. MEDICAL LICENSE NO.: 036-049311
29d. DATE SIGNED (Month, Day, Year): 1/26/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Lyle Munn, 4321 Fir St., East Chicago, IN 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander Williams M.D.
32. DATE FILED (Month, Day, Year): January 29, 1993

FILED
MAR 9 1993
AUDITOR LAKE COUNTY

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, state driver, passenger, pedestrian:

Agnes M Eaton
AUDITOR LAKE COUNTY

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SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER-PD 1