60 C.

93016408

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. C499-93 State No. ....

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)	ARTHUR HANSON
2 SEX	MALE
3a TIME OF DEATH	6:35 PM
3b DATE OF DEATH (Month Day Yr)	MARCH 7, 1993
4 SOCIAL SECURITY NUMBER	303-36-4315
5a AGE—Last Birthday (Years)	87
5b UNDER 1 YEAR (Months Days)	
5c UNDER 1 DAY (Hours Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	FEB.10,1906
7 BIRTHPLACE (City and State or Foreign Country)	CAMBRIDGE, MINNESOTA
8a WAS DECEDENT A U S VETERAN?	NO
8b YEAR LAST SERVED IN US ARMED FORCES?	NONE
9a PLACE OF DEATH (Check only one See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution give street and number)	OUR LADY of MERCY HOSPITAL
9c CITY TOWN OR LOCATION OF DEATH	DYER
9d COUNTY OF DEATH	lake
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife give maiden name)	gladys Lindgren
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	SERVICE STATION OWNER
12b KIND OF BUSINESS/INDUSTRY	SELF EMPLOYED
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY TOWN OR LOCATION	EAST CHICAGO
13d STREET AND NUMBER	4122 IVY STREET
13e ZIP CODE	46312
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[ ] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	[X] No [ ] Yes
16 RACE—American Indian, Black White etc (Specify)	WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	U/A
College (1-4 or 5+)	U/A

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	PETER P. HANSON
19 MOTHER'S NAME (First Middle Maiden Surname)	ANNA XXXXXX UNAVAILABLE

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	GLADYS HANSON
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State Zip Code)	4122 IVY ST. EAST CHICAGO, INDIANA 46312
20c Relationship	WIFE

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	PARK CREMATORY MARCH 9, 1993
21c LOCATION—City or Town State	PARK FOREST, ILLINOIS
22a EMBALMER'S NAME	ERIC PRUSIECKI
22b EMBALMER'S LICENSE NO	FDO 1022431
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Eric Prusiecki (signature)
24b LICENSE NUMBER (of Licensee)	FDO 1022431
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	PrusieckiFuneral Home,Inc.FDH3001562 Box, J,East Chicago,Ind. 46312

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. Septicemia - Hypo...

DUE TO (OR AS A CONSEQUENCE OF)

b. [illegible]

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

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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? 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c MEDICAL LICENSE NO	01226158
29d DATE SIGNED (Month Day Year)	3-8-93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ADELA M. PEREZ M.D. 2156 HART ST. DYER IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander L. Williams, MD (signature)

32 DATE FILED (Month Day Year): March 9, 1993

CORONER USE ONLY

Field	Entry
33 MANNER OF DEATH	[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
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	

00749 600

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

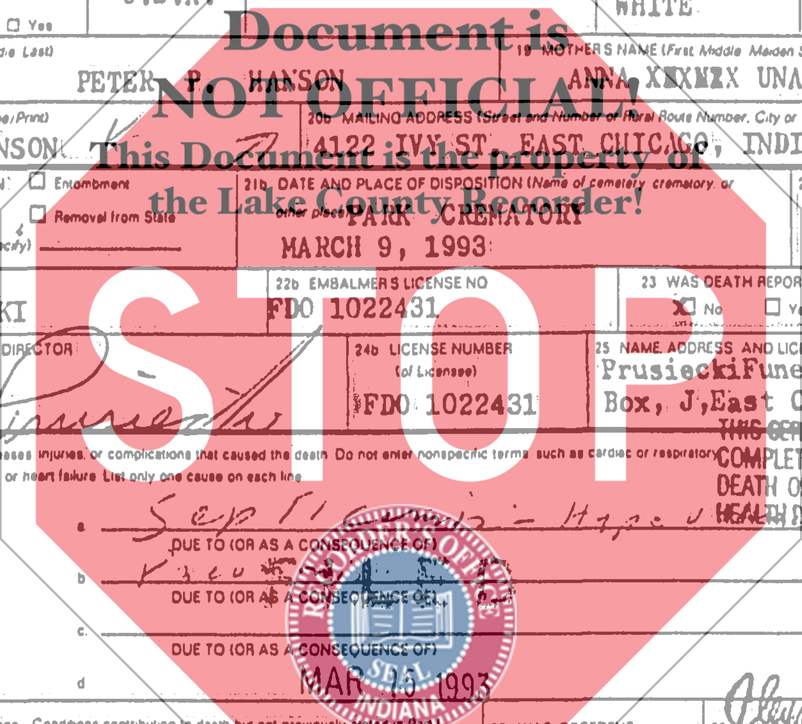
MAR 09 1993

Alexander L. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

MAR 15 1993

Anna N. Antonas AUDITOR LAKE COUNTY

#30-4860-31 - Pk. Add. T.H. 33 Bl. 10



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