93018926

Local No. 0424-92

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Frank R. Seidensticker, Jr.
2 SEX: male
3a TIME OF DEATH: 12:42 P.M.
3b DATE OF DEATH (Month Day Yr): March 17, 1992
4 SOCIAL SECURITY NUMBER: 358-16-0461
5a AGE—Last Birthday (Years): 65
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr): June 18, 1926
7 BIRTHPLACE (City and State or Foreign Country): Indianapolis
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): 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): Louise J. Savickas
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Consultant
12b KIND OF BUSINESS/INDUSTRY: Self employed
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 6825 Ridgeland
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS? ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Frank R. Seidensticker, Sr.
19 MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Shirley

INFORMANT

20a INFORMANT'S NAME (Type/Print): Louise J. Seidensticker
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6825 Ridgeland-hammond, IN 46324
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☒ Donation ☐ Entombment ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Anatomical Gift IN University School of Medicine
21c LOCATION—City or Town, State: Indianapolis, IN
22a EMBALMER'S NAME: Henry Blake
22b EMBALMER'S LICENSE NO: FD0109406
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: William C Huber
24b LICENSE NUMBER (of Licensee): FD01C01463
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Dalton & Son FH5002829, 6955 Southeastern-Hammond, IN 46324

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): Coronary occlusion
DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic heart d
DUE TO (OR AS A CONSEQUENCE OF): Nuclear disease
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last

Approximate Interval Between Onset And Death: 12 49 PM 3-93

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Psoriasis of skin; Nonspecific dermatitis

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: A.T. Willardo, MD
29c MEDICAL LICENSE NO: 20544
29d DATE SIGNED (Month, Day, Year): March 18, 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.T. Willardo, MD - 7150 Indianapolis Blvd - Hammond, IN 46324

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: A.T. Willardo, MD
MAR 26 1993
32 DATE FILED (Month Day, Year): March 18, 1992

CORONER USE ONLY

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 Ooccurred:
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.

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