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Local No. 0509-93

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): HAUN HAROLD
2. SEX: MALE
3a. TIME OF DEATH: 2:00 P M
3b. DATE OF DEATH (Month Day Yr): MARCH 7, 1993
4. SOCIAL SECURITY NUMBER: 310-18-9153
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): JANUARY 14, 1920
7. BIRTHPLACE (City and State or Foreign Country): DOWAGIAC, MICHIGAN
8a. WAS DECEDENT A US VETERAN?: YES
8b. YEAR LAST SERVED IN US ARMED FORCES?: WWII
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence
9b. FACILITY NAME (If not institution, give street and number): 2606 VERMILLION
9c. CITY, TOWN OR LOCATION OF DEATH: LAKE STATION
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): WIDOWED
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CHIEF GUNNERS MATE
12b. KIND OF BUSINESS/INDUSTRY: U. S. NAVY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 2606 VERMILLION STREET
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): WILLIS EARL HAUN
19. MOTHER'S NAME (First Middle Maiden Surname): LILLY SCHWARCK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DAVID HAUN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 830 W. 39TH STREET, HOBART, IN 46342
20c. Relationship: SON

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MARCH 10, 1993 BLAKE CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD08900027
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: [illegible]00269 BURNS FUNERAL HOME, BRADY CHAPEL 2781 CENTRAL AVE, LAKE STATION, IN

FILED JUN 29 1993

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

MAR 10 1993

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. Cancer of Prostate
DUE TO (OR AS A CONSEQUENCE OF):
b. Bone metastasis
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic obstructive lung disease

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

Approximate Interval Between Onset and Death

[signature] 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

SAM J. ORLICH RECORDER — JUN 30 9 28 AM '93

FILED IN LAKE COUNTY FOR RECORD — INDIANA S.S.

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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: [signature]
29c. MEDICAL LICENSE NO.: 01032180
29d. DATE SIGNED (Month Day, Year): 3/10/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SURENDRA J. SHAH MD, 5825 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], MD
32. DATE FILED (Month Day, Year): March 10, 1993

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 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

0138

#19-16-2
Lt 4 3 Blk 6 Carleton 1st Add.

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