93085883

Local No. 2855-93

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): DANIEL T. PAULS

2 SEX: MALE

3a TIME OF DEATH: 12:00 P

3b DATE OF DEATH (Month Day Yr): DECEMBER 12, 1993

4 SOCIAL SECURITY NUMBER: 306-01-8502A

5a AGE—Last Birthday (Years): 79

5b UNDER 1 YEAR (Months / Days):

5c UNDER 1 DAY (Hours / Minutes):

6 DATE OF BIRTH (Mo Day Yr): March 7, 1914

7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana

8a WAS DECEDENT A US VETERAN? No

8b YEAR LAST SERVED IN US ARMED FORCES? N/A

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution give street and number): THE COMMUNITY HOSPITAL

9c CITY TOWN OR LOCATION OF DEATH: MUNSTER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Ann Macko

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Shipping Clerk

12b KIND OF BUSINESS/INDUSTRY: Lever Bros. Co.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Hammond (Whiting P.O.)

13d STREET AND NUMBER: 1747 Lake Avenue

13e ZIP CODE: 46394

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): ; College (1-4 or 5+): 1

PARENTS

18 FATHER'S NAME (First Middle Last): Anthony Pauls

19 MOTHER'S NAME (First Middle Maiden Surname): Agnes Rimkus

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mrs. Ann Pauls

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1747 Lake Ave., Whiting, IN 46394

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): December 16, 1993 St. Casimir Cemetery

21c LOCATION—City or Town, State: Chicago, Illinois

22a EMBALMER'S NAME: Martin A. Dybel

22b EMBALMER'S LICENSE NO: FDE01019456

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Martin A. Dybel

24b LICENSE NUMBER (of Licensee): FDE01019456

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc., FDH83007267 1235-119th St., Whiting, IN 46394

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. Coronary Disease

DUE TO (OR AS A CONSEQUENCE OF): b. Renal Failure

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.

FILED DEC 20 1993 Anna M. Anton

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): N/A

28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

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: [signature]

29c MEDICAL LICENSE NO: 31764

29d DATE SIGNED (Month Day Year): DECEMBER 14, 1993

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): S.N. MAKAM, MD 9122 COLUMBIA AVENUE 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE FILED (Month Day, Year): December 15, 1993

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.

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