Donald R. O'Dell
P.O. Box 128 - 707 E. Commercial Ave
Lowell, Ind 46356

Local No. 069-93 93087621

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): Delphine L. Niemeyer
2 SEX: Female
3a TIME OF DEATH: 1:15 a.m.
3b DATE OF DEATH (Month Day Yr): March 30, 1993
4 SOCIAL SECURITY NUMBER: 341-16-4814
5a AGE—Last Birthday (Years): 71
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr): Jan. 25, 1922
7 BIRTHPLACE (City and State or Foreign Country): Chicago Hgts., Illinois
8a WAS DECEDENT A U S VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: N.A.
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): 13345 Calumet Avenue
9c CITY TOWN OR LOCATION OF DEATH: Cedar Lake
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Adolph Niemeyer
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Cafeteria Manager
12b KIND OF BUSINESS/INDUSTRY: Hanover Twp. Pub. School
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Cedar Lake
13d STREET AND NUMBER: 13345 Calumet Avenue
13e ZIP CODE: 46303
13f INSIDE CITY LIMITS? XX No ☐ Yes
13g ON A FARM? ☐ No XX 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): Charles Bremer
19 MOTHER'S NAME (First Middle Maiden Surname): Lena Podeis

INFORMANT

20a INFORMANT'S NAME (Type/Print): Adolph Niemeyer
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 13345 Calumet Avenue, Cedar LK, IN 46303
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): April 2, 1993 Zion United Church of Christ Cem.
21c LOCATION—City or Town State: Dyer, Indiana
22a EMBALMER'S NAME: William E. Burdan
22b EMBALMER'S LICENSE NO: FD01007697
23 WAS CASE REPORTED TO CORONER? XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
24b LICENSE NUMBER (of Licensee): FD01007697
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BURDAN FUNERAL HOME FH83002461 2900 Wilkes Ave Cedar LK IN 46303

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 (Disease or condition resulting in death):
a. Respiratory failure — Approximate Interval Between Onset and Death: 2 weeks
DUE TO (OR AS A CONSEQUENCE OF):
b. Metastatic uterine Sarcoma to lungs — 3 months
DUE TO (OR AS A CONSEQUENCE OF):
c. Metastatic uterine Sarcoma to liver — 5 months
DUE TO (OR AS A CONSEQUENCE OF):

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

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):

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: MD (Zajac)
29c MEDICAL LICENSE NO: 01040122
29d DATE SIGNED (Month Day Year): 4/5/93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 901 MacArthur Blvd. Munster, IN 46321 / ZAJAC M.D.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: MD
32 DATE FILED (Month Day Year): April 5, 1993

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 specify driver passenger pedestrian etc

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LAKE COUNTY RECORDER'S OFFICE INDIANA
DEC 2 10 1993
DEC 2 1993
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
93 DEC 26 AM 10:31

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