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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0544-94

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)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
JOHN	GAUL	SR.	MALE	5:39 P.M.	MARCH 9, 1994

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
313-18-4422	71			September 3,1922	Chicago Hts.,Illinois

8a WAS DECEDENT A U S VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See Instructions)
Yes	1943	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
married	Helen Riebe	Proprietor	Hardware Store

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	1042 Spruce

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46324	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	12	

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Charles Gaul	Anna Sewczyk

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Helen Gaul	1042 Spruce, Hammond, Indiana 46324	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	March 12, 1994 St. Nicholas Cemetery	Hammond, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Dean G. Wagner	FD# 8800057	[X] [ ]

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
John A. Bruyn	FD# 1007231	SOLAN FUNERAL HOME FH# 83002893 7209 Calumet Ave,Hammond,Ind.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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF) b. ARTERIOSCLEROTIC HEART DISEASE	
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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
no	No	--

CERTIFIER

29a. CERTIFIER (Check only one)

- [X] 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	29c. MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Burton M. Greenberg, M.D.	~~29887~~ 23250	MARCH 10 1994

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

DR. BURTON GREENBERG, M.D. 912 COLUMBIA AVENUE MUNSTER, INDIANA 46321

31 HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander D. Williams, M.D.	March 11, 1994

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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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