Sunway Addition Lot 29
Key # 29-125-29; unit # 28

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Hammond Health Commissioner

Oct 1, 1993
Date Issued

94024679

Local No. 808

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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): HAROLD E. BURGAN
2 SEX: MALE
3a TIME OF DEATH: 10:57 A
3b DATE OF DEATH (Month Day Year): September 29, 1993
4 SOCIAL SECURITY NUMBER: 348-22-7860
5a AGE—Last Birthday (Years): 63
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): DECEMBER 1, 1929
7 BIRTHPLACE (City and State or Foreign Country): CLAIRMONT, ILLINOIS
8a WAS DECEDENT A US VETERAN?: YES
8b YEAR LAST SERVED IN US ARMED FORCES?: 1956
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): ST. MARGARET HOSPITAL
9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife give maiden name): LORENE BLAIR
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): METALLURGIST
12b KIND OF BUSINESS/INDUSTRY: INLAND STEEL
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: WHITING
13d STREET AND NUMBER: 2606 White Oak Avenue
13e ZIP CODE: 46394
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): ; College (1-4 or 5+): 4

PARENTS

18 FATHER'S NAME (First Middle Last): VALA BURGAN
19 MOTHER'S NAME (First Middle Maiden Surname): GERALDINE UMFLEET

INFORMANT

20a INFORMANT'S NAME (Type/Print): LORENE BURGAN
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2606 White Oak 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): 02 October 1993, St. John Cemetery
21c LOCATION—City or Town, State: Hammond, Indiana
22a EMBALMER'S NAME: THOS. OWENS
22b EMBALMER'S LICENSE NO: FDE1001049
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thos Owens
24b LICENSE NUMBER (of Licensee): FDE 1001049
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: OWENS FUNERAL HOME, FDH 3007291, 816-119th 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Lymphoma — Approximate Interval Between Onset and Death: 6 years
DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last
b.
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): 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): N/A

FILED
APR 4 1994

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: 01036259
29d DATE SIGNED (Month, Day, Year): 09-30-93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. GLEATON, M.D., 7905 CALUMET AVE., MUNSTER, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Bermudez M.D.
32 DATE FILED (Month, Day, Year): October 1, 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.

906378 / 809

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