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C473976

Local No. 0167-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Bernice A. Becker
2 SEX: Female
3a TIME OF DEATH: 6:45A.M.
3b DATE OF DEATH (Month Day Yr.): January 23, 1993
4 SOCIAL SECURITY NUMBER: 315-52-6048
5a AGE—Last Birthday (Years): 90
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo Day Yr.): JAN 16, 1903
7 BIRTHPLACE (City and State or Foreign Country): Crown Point, IN
8a WAS DECEDENT A U.S. VETERAN?: No
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
8c 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): Lutheran Home of Northwest IN.
9c CITY TOWN OR LOCATION OF DEATH: Crown Point
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): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Her Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Crown Point
13d STREET AND NUMBER: 802 E. Joliet Street
13e ZIP CODE: 46307
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16 RACE—American Indian, Black, White etc. (Specify): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): John Claussen
19 MOTHER'S NAME (First Middle Maiden Surname): Anna Kuehl

INFORMANT

20a INFORMANT'S NAME (Type/Print): Donald Becker
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 E. Joliet St,, Crown Point, IN 46307
20c Relationship: Son

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JAN 25, 1993 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Larry A. Geisen
22b EMBALMER'S LICENSE NO: FD09000013
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Robert P. Geisen
24b LICENSE NUMBER (of Licensee): FD01000328
24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FD83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN 46307

CAUSE OF DEATH

28. 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. Acute Pulmonary Edema
DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF):

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

Approximate Interval Between Onset and Death:

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): (illegible)
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

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: Bernardo S. Lucena
29c MEDICAL LICENSE NO: 01039302
29d. DATE SIGNED (Month, Day, Year): 1-25-93

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Bernardo S. Lucena M.D., 12110 [illegible] Street, Crown Point, IN 46307
31 HEALTH OFFICER'S SIGNATURE: (illegible)
32. DATE FILED (Month, Day, Year): Jan. 25, 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 Ooccurred:
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.:

FILED
APR 6 1994

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

Anna N. Antos