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Local No. 425

INDIANA STATE BOARD OF HEALTH

94029771

CERTIFICATE OF DEATH

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

MAY 14,1990 Franklin D. Brunder M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Harriett Louise Keller
2 SEX: Female
3a TIME OF DEATH: 7:00 p.m
3b DATE OF DEATH (Month, Day, Yr.): May 12, 1990
4 SOCIAL SECURITY NUMBER: 313-36-8791
5a AGE—Last Birthday (Years): 54
5b UNDER 1 YEAR — Months / Days:
5c UNDER 1 DAY — Hours / Minutes:
6 DATE OF BIRTH (Mo., Day, Yr.): April 26,1936
7 BIRTHPLACE (City and State or Foreign Country): Lime Springs, Iowa
8a WAS DECEDENT A U.S. VETERAN? No
8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---
9a PLACE OF DEATH (Check only one. See instructions.): [X] HOSPITAL — Inpatient; [ ] ER/Outpatient; [ ] DOA; [ ] OTHER — Nursing Home; [ ] Other (Specify); [ ] Residence
9b FACILITY NAME (If not institution, give street and number): St. Margaret's 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): Jerry Keller
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Secretary
12b KIND OF BUSINESS/INDUSTRY: Medical
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Merrillville
13d STREET AND NUMBER: 7843 Colorado Street
13e ZIP CODE: 46410
13f INSIDE CITY LIMITS? [X] No [ ] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): Harry Johnson
19 MOTHER'S NAME (First, Middle, Maiden Surname): Frances Green

INFORMANT

20a INFORMANT'S NAME (Type/Print): Jerry Keller
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7843 Colorado Street.Merrillville, IN 46410
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 15, 1990 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Ronald J. Mesarch
22b EMBALMER'S LICENSE NO.: FD01005912
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Ronald J. Mesarch
24b LICENSE NUMBER (of Licensee): FD01005912
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762 7905 Broadway Merrillville, IN 46410

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. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. Subarachnoid hemorrhage
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.

Approximate Interval Between Onset and Death

FILED
APR 19 1994
RECORDER'S OFFICE LAKE COUNTY INDIANA

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 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):
[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.: 29360
29d DATE SIGNED (Month, Day, Year): May 14, 1990

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. Krad, M.D. 509 Ridge Road, Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): MAY 14, 1990

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.

Resub of the Resub L-11 to 27 Inc Bl 5 Green Acres Dr to Resub L-51 & 52 Bl 5 Green Acres Dr to L-55 & 56 Ex E 30 ft

Key #53-25-32 Unit #43

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