

7-8-21 & 35

Donald O'Neil
P.O. Box 128
Snell 46358
7

ATTENTION ESTATE: Disclosure of the
SSN we need to pursue our responsibilities
is voluntary and there will be no penalty for
refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 2839-54

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

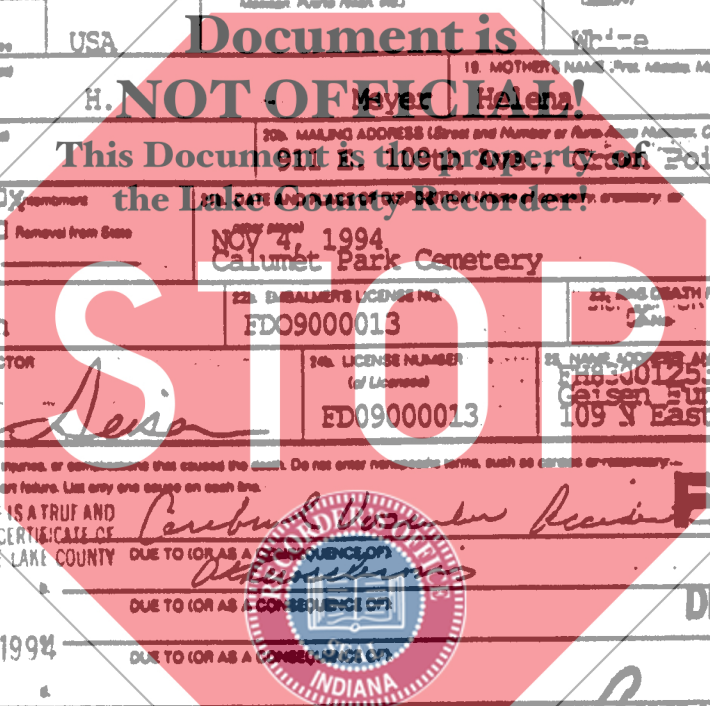
DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (Type Middle Last) Harvey H. Meyer		2. SEX Male	3a. TIME OF DEATH 2:55A	3b. DATE OF DEATH (Month Day Year) October 31, 1994
4. SOCIAL SECURITY NUMBER 317-07-0292	5a. AGE—Last Birthday (Year) 84	5b. UNDER 1 YEAR (Month Day) Months Days	5c. UNDER 1 DAY (Hours Minutes) Hours Minutes	6. DATE OF BIRTH (Month Day Year) SEP 13, 1910
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	
9a. FACILITY NAME (If not institution, give street and number) 911 E. 109th Ave.		9b. CITY/TOWN OR LOCATION OF DEATH Crown Point		9c. COUNTY OF DEATH Lake
10. MARRITAL STATUS Married	11. SURVIVING SPOUSE (If wife, give maiden name) Lois Vanatta	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Custodian		12b. KIND OF BUSINESS/INDUSTRY Crown Point School
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY/TOWN OR LOCATION Crown Point		13d. STREET AND NUMBER 311 E. 109th Ave.
15a. ZIP CODE 46307	15b. INSIDE CITY LIMITS (Yes/No) Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) No	16. RACE—American Indian, Black, Other, White White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary; Secondary (9-12); College (1-4 or 5+) 10		18. DECEDENT'S FATHER'S NAME (First Middle Last) Harry H. Meyer		
19. DECEDENT'S MOTHER'S NAME (First Middle Last) Helena Meyer		20. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crown Point, IN 46307		
21a. METHOD OF DISPOSITION (Check one) <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) NOV 4, 1994 Calumet Park Cemetery		21c. LOCATION—City, State, Zip Code Merrillville, IN 46307
22a. EMBALMER'S NAME Larry A. Geisen		22b. EMBALMER'S LICENSE NO. EDO9000013		22c. WAS DEATH REPORTED TO CORONER? No
23a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry A. Geisen</i>		23b. LICENSE NUMBER (of Licensee) EDO9000013		23c. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Edo 301253 Geisen Funeral Home, Inc. 109 N East St., Crown Point, IN 46307
24. PART I. Enter the diseases, injuries, or conditions that caused the death. Do not enter nonspecific terms, such as cardiac arrhythmia, stroke, shock, or heart failure. List only one cause on each line. THIS CERTIFICATE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT NOV 16 1994 Carbonyl Hemoglobin Binding Adiposclerosis DEC 30 1994				
25. PART II. Enter conditions that contributed to death but not previously stated in Part I. Alcohol Abuse LAKE COUNTY HEALTH COMMISSIONER		26. WAS DECEDENT PREPREGNANT OR DID SHE HAVE POSTPARTUM INFECTION? (Yes or no) No		27. WAS AN AUTOPSY PERFORMED? (Yes or no) No
28. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.		29a. SIGNATURE AND TITLE OF CERTIFIER <i>B. Pumputis</i>		29b. MEDICAL LICENSE NO. 01032732
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 28D (Type/Print) B. Pumputis M.D., 300 West 80th Place, Merrillville, IN 46410		29c. DATE SIGNED (Month Day Year) 11-2-94		
31. HEALTH OFFICER'S SIGNATURE <i>Donald O'Neil</i>		32. DATE FILED (Month Day Year) November 3, 1994		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day Year) NOV 13 1994		34b. DESCRIBE HOW INJURY OCCURRED 001638
34c. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 000		34d. LOCALITY (Street and Number or Rural Route Number, City or Town, State)		
34e. DATE PRONOUNCED DEAD (Month Day Year)		34f. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		



7-8-21 & 7-8-35

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
NOV 5 1994
Merrillville, Indiana