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TENTION ESTATE: Disclosure of the # we need to pursue our responsibilities voluntary and there will be no penalty for ual.*

INDIANA STATE DEPARTMENT OF HEALTH

cal No. 2926-94 — **CERTIFICATE OF DEATH** — State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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CEDENT

RENTS

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POSITION

USE OF ATH

RTIFIER

LTH FICER

1 DECEASED—NAME (First Middle Last) EDWARD JAMES WAGNER			2 SEX MALE	3a TIME OF DEATH 2:30 PM	3b DATE OF DEATH (Month Day Yr) NOVEMBER 14, 1994
4 *SOCIAL SECURITY NUMBER 306-24-8966	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr.) 8-21-26	7 BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA
8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA		OTHER ☐ Nursing Home ☒ Other (Specify) HOSPICE ☐ Residence	
9b FACILITY NAME (If not institution, give street and number) 1704 E. 73rd AVENUE		9c CITY, TOWN OR LOCATION OF DEATH MERRILLVILLE		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) DIANE STERLING	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ENGINEER		12b KIND OF BUSINESS/INDUSTRY U.S. STEEL	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION MERRILLVILLE		13d STREET AND NUMBER 1704 E. 73rd AVENUE	
13e ZIP CODE 46410	13f INSIDE CITY LIMITS? ☐ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12 / College (1-4 or 5+) 4
	13g ON A FARM? ☒ No ☐ Yes				
18 FATHER'S NAME (First, Middle, Last) EUGENE WEBSTER			19 MOTHER'S NAME (First, Middle, Maiden Surname) MARY GERBA		
20a INFORMANT'S NAME (Type/Print) DIANE WAGNER		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1704 E. 73rd Avenue, Merrillville, IN. 46410			20c Relationship WIFE
21a METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) November 17, 1994 Holy Cross Cemetery		21c LOCATION—City or Town, State Calumet City, Illinois	
22a EMBALMER'S NAME JAMES F. BETKOWSKI		22b EMBALMER'S LICENSE NO FD09200077		23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR James F. Betkowski		24b LICENSE NUMBER (of Licensee) FD09200077		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BARAN & SON FHD #83007267 1235-119th ST. WHITING, INDIANA ELMWOOD CHAPEL CHICAGO, ILLINOIS 606	

26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac 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. Malignant Brain Tumor	
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. DUE TO (OR AS A CONSEQUENCE OF)	

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)

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	115-48-0048	11-15-94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Adolphus A. Anekwe, M.D. 3195 Broadway, Gary, Indiana

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Alexander D. Williams MD	November 16, 1994

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.			

Key # 53-81-10

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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