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

2124-94

# INDIANA STATE DEPARTMENT OF HEALTH

Local No. .....

## CERTIFICATE OF DEATH

State No. .....

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): Ivan L. Larson
2. SEX: Male
3a. TIME OF DEATH: 12:02 A M
3b. DATE OF DEATH (Month, Day, Yr.): September 5, 1994
4. SOCIAL SECURITY NUMBER: 309-09-0281
5a. AGE—Last Birthday (Years): 86
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day Yr.): Feb. 5, 1908
7. BIRTHPLACE (City and State or Foreign Country): UNK Wisconsin
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): The Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Helen Westphal
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Line O Type Operator
12b. KIND OF BUSINESS/INDUSTRY: Newspaper
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Griffith
13d. STREET AND NUMBER: 723 40th Pl.
13e. ZIP CODE: 46319
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY: U.S.A.
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): UNK; College (1 4 or 5 +): UNK

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): Unavailable
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Obee Larson

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Helen Larson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 723 40th Pl Griffith, Indiana
20c. Relationship: Wife

**DISPOSITION**

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 8, 1994 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO.: FDO 1016713
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: E K Kuiper
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinmann Rd. Highland, Indiana fDH 300-7500

**CAUSE OF DEATH**

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): Cardiac Arrest — DUE TO (OR AS A CONSEQUENCE OF): Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF): — DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: SEP 7 1994

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE DUE TO (OR AS A CONSEQUENCE OF) ON FILE WITH THE LAKE COUNTY HEALTH DEPT

FILED JAN 23 1995 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 JAN 23 PM 3:39

PART II. Other significant conditions contributing to death but not resulting in Part I: Alexander D. Williams, M.D.

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)

**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: Peter G. Mavrelis
29c. MEDICAL LICENSE NO.: 01030831
29d. DATE SIGNED (Month, Day, Year): 9/7/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): PETER G. MAVRELIS, M.D. 8898 Broadway, Merrillville, IN 46410

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams, M.D.
32. DATE FILED (Month, Day, Year): Sept. 7, 1994

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.

Key # 26-2268-22

965

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

Bob Pete 2110 N. Main St. Crown Point, IN 46307