

P4 W 1/2 NE S. 7 T. 35 R. 9 O. 89 AC
55X 707.2754 W 304 O. 03 75 AC

INDIANA STATE BOARD OF HEALTH in ST

CERTIFICATE OF DEATH

Key # 14-101-16
State No.

Unit # 12

Local No. 263-89

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

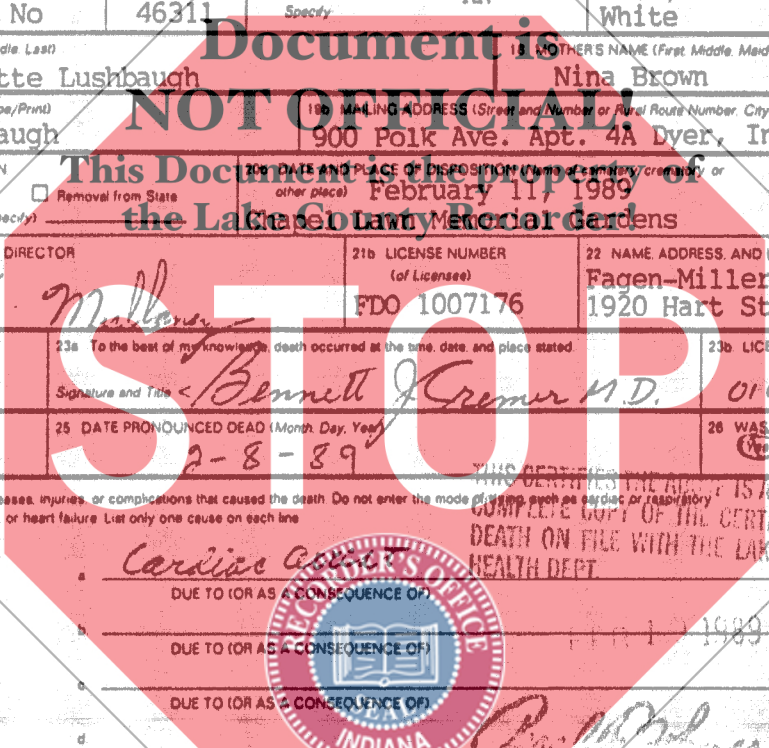
SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1 DECEASED—NAME FIRST MIDDLE LAST ROBERT E. LUSH BAUGH			2 SEX Male	3 DATE OF DEATH (Mo. Day Yr) February 8, 1989	
4 SOCIAL SECURITY NUMBER 351-12-1163	5a AGE—Last Birthday (Years) 78	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) Oct. 3, 1910	
8 YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution give street and number) Our Lady of Mercy Hospital		9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS—Married Never Married Widowed. Divorced (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ruth Evans	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Welder	12b KIND OF BUSINESS/INDUSTRY Steel Co.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Dyer	13d STREET AND NUMBER 900 Polk Ave. Apt. 4A		
13e INSIDE CITY LIMITS? (Yes or no) Yes	13f FARM No	13g ZIP CODE 46311	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban Mexican Puerto Rican, etc.) XX No <input type="checkbox"/> Yes <input type="checkbox"/> Specify	15 RACE—American Indian, Black White etc (Specify) White	
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		17 FATHER'S NAME (First Middle Last) Erith Everette Lushbaugh			
18 MOTHER'S NAME (First Middle Maiden Surname) Nina Brown		19a INFORMANT'S NAME (Type/Print) Ruth Lushbaugh			
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Polk Ave. Apt. 4A Dyer, Indiana 46311		19c Relationship Wife			
20a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) February 11, 1989 Lakeside Memorial Gardens		20c LOCATION—City or Town, State Scherverville, Indiana	
21a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mallory</i>		21b LICENSE NUMBER (of Licenses) FDO 1007176	22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens Inc. 1920 Hart St. Dyer, Indiana 46311 FD83001504		
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <i>Bennett J. Bremer M.D.</i>		23b LICENSE NUMBER 01021027	23c DATE SIGNED (Month, Day, Year) 2-8-89		
24 TIME OF DEATH 8:44 P.M.		25 DATE PRONOUNCED DEAD (Month, Day, Year) 2-8-89		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes/No) No	
27 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter the mode of death 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) Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF) Sequitally list conditions, if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death). LAST DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)		PART II: Other significant conditions contributing to death but not resulting in the underlying cause(s) given in Part I. Cardiac arrhythmia congestive heart failure			
28a WAS AN AUTOPSY PERFORMED? No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)			
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Ruth Lushbaugh</i>			
29c LICENSE NUMBER 1055397		29d DATE SIGNED (Month, Day, Year) 2/9/89			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/print) Ray J. Zimmerman 1326 US Rte 30 Scherverville, Indiana 46375					
31 HEALTH OFFICER'S SIGNATURE <i>Paul Johnson</i>			32 DATE FILED (Month, Day, Year) February 10, 1989		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes/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) 00039			



FILED
JUN 7 1995
SAM ORLICH
AUDITOR LAKE COUNTY