

2480516 9

LF 450



STATE OF MICHIGAN DEPARTMENT OF PUBLIC HEALTH CERTIFICATE OF DEATH

STATE FILE NUMBER

0917188

TYPE/PRINT OR PERMANENT BLACK INK

Chicago Title Insurance Company

NAME OF DECEDENT FOR USE BY PHYSICIAN OR INSTITUTION

26-37 Sec 14 Key 46-146-4 + 6

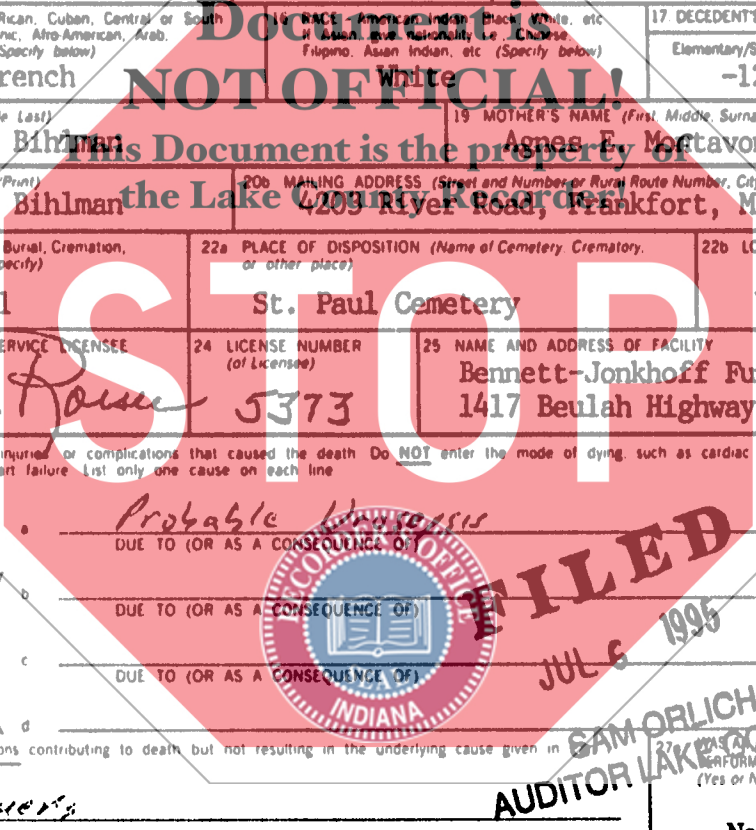
CAUSE OF DEATH

CERTIFIER

MEDICAL EXAMINER

B-36 Rev. 1/90

1 DECEDENT'S NAME (First, Middle, Last) Ralph A. Bihlman				2 SEX Male	3 DATE OF DEATH (Month, Day, Year) July 4, 1994
4a AGE - Last Birthday (Years) 87	4b UNDER 1 YEAR MONTHS 8 DAYS 12	4c UNDER 1 DAY HOURS 12 MINUTES 00	5 DATE OF BIRTH (Month, Day, Year) September 22, 1906	6 COUNTY OF DEATH Grand Traverse	
7a LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number) Grand Traverse Medical Care Facility			7b IF HOSP OR INST Inpatient, Op/Emer Room, DOA (Specify) Inpatient	7c CITY, VILLAGE, OR TOWNSHIP OF DEATH City of Traverse City	
8 SOCIAL SECURITY NUMBER 306-01-9070		9a USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) President		9b KIND OF BUSINESS OR INDUSTRY Asphalt and Trucking	
10a CURRENT RESIDENCE - STATE Michigan	10b COUNTY Benzie	10c LOCALITY (Check one box and specify) <input type="checkbox"/> INSIDE CITY OR VILLAGE OF <input checked="" type="checkbox"/> TWP OF Crystal Lake		10d STREET AND NUMBER 4203 River Road	
10e ZIP CODE 49635	11 BIRTHPLACE (City and State or Foreign Country) Portsmouth, OH.	12 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married	13 SURVIVING SPOUSE (If wife, give name before first married) Mary M. Von Lührte	14 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) No	
15 ANCESTRY - Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc (Specify below) German/French		16 RACE - American Indian, Black, White, etc (If Asian, give nationality, e.g., Chinese, Filipino, Asian Indian, etc (Specify below)) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) 9503783	
18 FATHER'S NAME (First, Middle, Last) Frank N. Bihlman		19 MOTHER'S NAME (First, Middle, Surname before first married) Agnes E. Mottavon			
20a INFORMANT'S NAME (Type/Print) David R. Bihlman		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, ZIP Code) 4203 River Road, Frankfort, MI. 49635			
21 METHOD OF DISPOSITION - Burial, Cremation, Removal, Donation, Other (specify) Burial		22a PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place) St. Paul Cemetery	22b LOCATION - City or Village. Valparaiso, Indiana		
23 SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. House</i>		24 LICENSE NUMBER (of Licensee) 5373	25 NAME AND ADDRESS OF FACILITY Bennett-Jonkhoff Funeral Home 1417 Beulah Highway, Beulah, MI. 49617		
26 PART I Enter the diseases, injuries, or complications that caused the death. Do NOT enter the mode of dying, 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) Probable Myocarditis		DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death 2 days	
Sequentially 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)	
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Alzheimer's		DUE TO (OR AS A CONSEQUENCE OF)		DUE TO (OR AS A CONSEQUENCE OF)	
28 ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify) Nursing Home		29 WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No) No		31a (Check one only) <input type="checkbox"/> The case reviewed and determined not to be a medical examiner's case <input type="checkbox"/> On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated	
30a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated (Signature and Title) <i>Mark Jackson MD</i>		30b DATE SIGNED (Mo, Day, Yr) July 5, 1994		30c TIME OF DEATH 2:00 p.m.	
30d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		31b DATE SIGNED (Mo, Day, Yr)		31c CASE NUMBER	
32a NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type or Print) Mark Jackson 3601 W Front St Traverse City, MI. 49684		32b LICENSE NUMBER 055155		31d PRONOUNCED DEAD (Mo, Day, Yr) ON	
33a ACC SUICIDE, MOM, NATURAL OR PENDING INVEST (Specify)		33b DATE OF INJURY (Mo, Day, Yr)		33c TIME OF INJURY M	
33e INJURY AT WORK (Specify Yes or No)		33f PLACE OF INJURY At home, farm, street, factory, office building, etc (Specify)		33d DESCRIBE HOW INJURY OCCURRED 000246	
34a REGISTRAR'S SIGNATURE <i>Diane Jackson</i>		34b DATE FILED (Month, Day, Year) July 7, 1994		31e TIME OF DEATH M	



FILED JUL 6 1995 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD MARGARET C. REEDER 95 JUL -6 PM 22

11-88

220010000



STATE OF MICHIGAN
COUNTY OF GRAND TRAVERSE



I HEREBY CERTIFY THIS COPY TO BE A
TRUE AND CORRECT COPY OF THE
RECORD ON FILE WITH THE OFFICE OF
COUNTY CLERK

VIRGINIA A. WATSON
GRAND TRAVERSE COUNTY CLERK

BY: *Virginia A. Watson*
DEPUTY COUNTY CLERK

DATE: 7-7-94