H 481765 LD ①

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0433-93 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): ADOLPHE J. DESTJEAN
2 SEX: MALE
3a TIME OF DEATH: 8:55A M
3b DATE OF DEATH (Month, Day, Yr): FEBRUARY 27, 1993
4 SOCIAL SECURITY NUMBER: 312-09-0460
5a AGE—Last Birthday (Years): 82
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): Oct. 3, 1910
7 BIRTHPLACE (City and State or Foreign Country): Spring Valley, IL.
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 ☒ 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): Gertrude Szozda
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor
12b KIND OF BUSINESS/INDUSTRY: Steel Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Highland
13d STREET AND NUMBER: 3620 43rd. st.
13e ZIP CODE: 46322
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? ☒ 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+)

PARENTS

18 FATHER'S NAME (First, Middle, Last): Julius De St Jean
19 MOTHER'S NAME (First, Middle, Maiden Surname): Unavailable

INFORMANT

20a INFORMANT'S NAME (Type/Print): Gertrude De St Jean
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3620 43rd st. Highland, Indiana
20c RELATIONSHIP: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 3, 1993 Oakland Memory Lane
21c LOCATION—City or Town, State: Dolton, Illinois
22a EMBALMER'S NAME: David Peterson
22b EMBALMER'S LICENSE NO: FDO 8601585
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Fuenral Home 9039 Kleinman 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 or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Ventricular arrythmia
DUE TO (OR AS A CONSEQUENCE OF): Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF): Acute Anterior Myocardial Infarct
DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease

Approximate Interval Between Onset and Death: 7; 15 year

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II. Other significant 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)

CERTIFIER

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: [signature]
29c MEDICAL LICENSE NO: 35471
29d DATE SIGNED (Month, Day, Year): FEBRUARY 28 199
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): HARISH SHAH, MD 209 E. 86TH COURT MERRILLVILLE, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S Williams MD
32 DATE FILED (Month, Day, Year): March 2 1993

FILED

CORONER USE ONLY

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.

SCH06-004 State Form 10110 (R3 / 3-92) DEATHCER PD 1

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT. AUG 16 1995
Alexander S Williams MD
LAKE COUNTY HEALTH COMMISSIONER

SEP 6 1995
SAM ORLICH
AUDITOR LAKE COUNTY
000187

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD SEP -6 PM 1:...

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