MAIL TAX BILLS TO: Mrs. Alice M. Wagner, as Trustee
3547 - 41st Street
Highland, IN 46322

Tax Key No. 27-286-10

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 10528-88

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: First: Frank | Middle: L. | Last: Wagner
2. SEX: M
3. DATE OF DEATH (Mo. Day Yr.): May 13, 1988
4. SOCIAL SECURITY NUMBER: 171-14-2271
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month Day, Year): Nov.7,1919
7. BIRTHPLACE (City and State or Foreign Country): Vandergrift, Pa.
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
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—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Alice Kemp
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Manager-Electrical
12b. KIND OF BUSINESS/INDUSTRY: Gas-Electric Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Highland
13d. STREET AND NUMBER: 3547 41st St.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46322
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes 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+): 4

PARENTS

17. FATHER'S NAME (First, Middle, Last): Charles Wagner
18. MOTHER'S NAME (First, Middle, Maiden Surname): Celeste Vageuner

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Alice Wagner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3547 41st St. Highland, Indiana
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 16, 1988 Concordia Cemetery
20c. LOCATION—City or Town, State: Hammond, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): FDE1014511
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH300-7500

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

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

24. TIME OF DEATH: M
25. DATE PRONOUNCED DEAD (Month, Day, Year)
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

CAUSE OF DEATH (SEE INSTRUCTIONS)

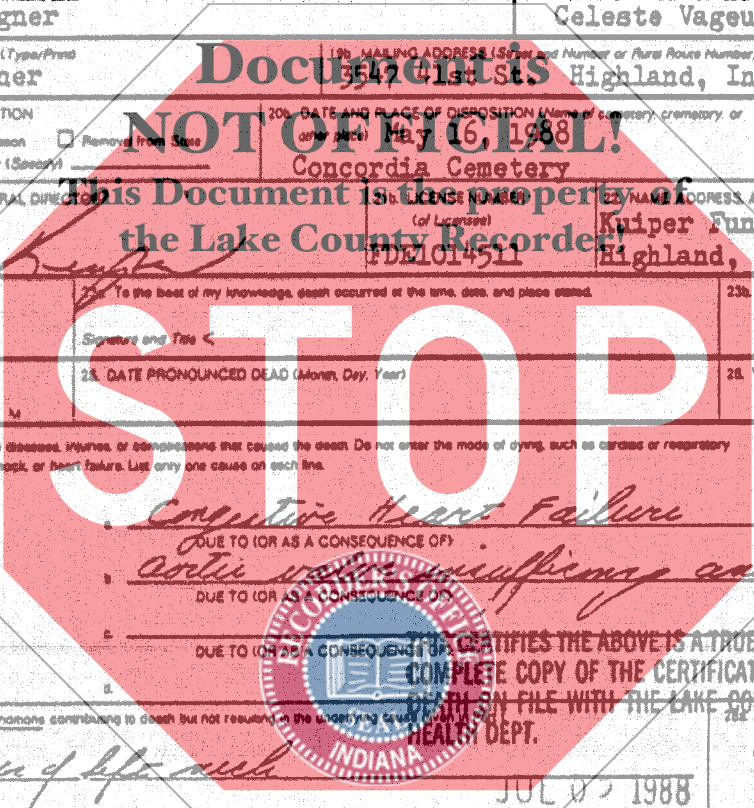
27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. aortic valve insufficiency and stenosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause: cancer of left neck

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

JUL 0 1988

FILED

SEP 6 1995

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF IN. LAKE CO. FILED FOR RECORD
95 SEP -6

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
[ ] 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.
[X] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to 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.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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.

LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond J Zimmerman MD
29c. LICENSE NUMBER: 01035397
29d. DATE SIGNED (Month, Day, Year): May 16, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Russell Johnson MD
32. DATE FILED (Month, Day, Year): MAY 17 - 198[8]

CORONER OR MEDICAL EXAMINER 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)

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