

196018 Ticket NO

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 0862-93

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-1-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

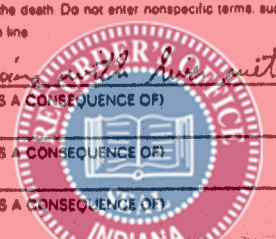
HEALTH OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First Middle Last) Alma M. Lenz		2 SEX Female	3a TIME OF DEATH 11:32 PM	3b DATE OF DEATH (Month Day, Yr) April 22, 1993
4 SOCIAL SECURITY NUMBER 312-18-2588	5a AGE—Last Birthday (Years) 83	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) September 30, 1909
7 BIRTHPLACE (City and State or Foreign Country) Vincennes, Indiana	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 8745 Jane Way		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) John Lenz	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife		12b KIND OF BUSINESS/INDUSTRY Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 8745 Jane Way	
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) 12		18 FATHER'S NAME (First Middle, Last) Theodore Reitmeyer		
19 MOTHER'S NAME (First Middle, Maiden Surname) Laura Oexman		20a INFORMANT'S NAME (Type/Print) John Lenz		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8745 Jane Way, Munster, Indiana 46321		20c Relationship Husband		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 26, 1993 Concordia Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME Henry J. Blake		22b EMBALMER'S LICENSE NO. FD01019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR Elden V. LaHayne		24b LICENSE NUMBER (of Licensee) FD01041928	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHAYNE Funeral Home, Inc., F3300 5746 Hohman Ave., Hammond, Indiana 46306	
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. THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. APR 26 1993				
PART II Other significant conditions—Conditions contributing to death but not previously stated in Part I Alleviated by painkillers, etc.				
27 WAS DECEDENT PREGNANT OR 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) NO
29a CERTIFIER <input checked="" type="checkbox"/> LAKE COUNTY HEALTH COMMISSIONER <input type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 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. 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 James B. Walsh		29c MEDICAL LICENSE NO. 27487	29d DATE SIGNED (Month, Day, Year) April 23, 1993	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) James B. Walsh, M.D., 5500 Hohman Ave., Hammond, Indiana 46320				
31 HEALTH OFFICER'S SIGNATURE Alexander S. Williams, M.D.				32 DATE FILED (Month, Day, Year) April 26, 1993
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.		000267		

18-28-363-77

STOP
This Document is the property of the Lake County Recorder!



FILED

NOV 3 1995

SAMORLICH LAKE COUNTY

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
NOV 3 1995
10:23
MORTUARY RECORDS

900
W
SK