

INDIANA STATE DEPARTMENT OF HEALTH

Josephine Getzlaff
1500 Thornhill Dr.
Schererville, IN 46373

Local No. 0789-43

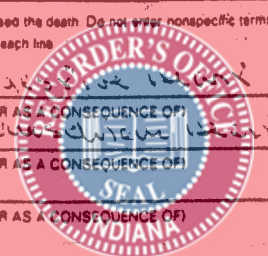
CERTIFICATE OF DEATH

State No. 46373

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TYPE/PRINT IN PERMANENT BLACK INK	1 DECEASED—NAME (First Middle Last) Carl O. Getzlaff		2 SEX Male		3a TIME OF DEATH 4:35 M		3b DATE OF DEATH (Month Day Year) April 3, 1993	
	4 SOCIAL SECURITY NUMBER 321-09-9660		5a AGE—Last Birthday (Years) 74		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
DECEDENT	6 DATE OF BIRTH (Mo Day Yr) August 3, 1918		7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois					
	8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
PARENTS	9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy			9c CITY, TOWN, OR LOCATION OF DEATH Dyer			9d COUNTY OF DEATH Lake	
	10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Josephine Perry		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Electrician Foreman		12b KIND OF BUSINESS/INDUSTRY Commonwealth Edison	
INFORMANT	13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Schererville		13d STREET AND NUMBER 1500 Thornhill Drive	
	13e ZIP CODE 46375		13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
DISPOSITION	16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (12) College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) Oscar G. Getzlaff		19 MOTHER'S NAME (First Middle Maiden Surname) Rose Tonn	
	20a INFORMANT'S NAME (Type/Print) Josephine Getzlaff		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 1500 Thornhill Dr. Schererville, IN		20c Relationship Wife		21a 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)	
CAUSE OF DEATH	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) April 6, 1993 Chapel Lawn		21c LOCATION—City or Town State Schererville, IN.		22a EMBALMER'S NAME David Semplinski		22b EMBALMER'S LICENSE NO. FD08600686	
	22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		23 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Stilnovich & Wiatrowski, 7535 Taft Merrillville, IN		24 SIGNATURE OF FUNERAL DIRECTOR Robert Wiatrowski		24b LICENSE NUMBER (of Licensee) FD01001293	
CORONER USE ONLY	25 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) a. <i>Coronary artery disease</i> b. <i>Myocardial infarction</i> c. <i>Due to (or as a consequence of) atherosclerosis</i>		26 PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO	
	28b CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) as stated. <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) as stated. <input type="checkbox"/> 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 Samonix Munnery, MD		29c MEDICAL LICENSE NO. 01023250		29d DATE SIGNED (Month/Day/Year) 4/14/93	
HEALTH OFFICER	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) Dr. Greenberg 9122 Columbia Ave. Munster, IN: 46321							32 DATE FILED (Month Day Year) April 16, 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)	
CORONER USE ONLY	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					

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FILED NOV 08 1993

AUDIT SAMORLICH FOR LAKE COUNTY

Key # 13-435-27

STATE OF INDIANA
LAKE COUNTY RECORDS
NOV 8 1993

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