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* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 02059-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): George A. Hurst

2 SEX:

3a TIME OF DEATH: 02:30A M

3b DATE OF DEATH (Month Day Yr): September 8, 1995

4 *SOCIAL SECURITY NUMBER: - -

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): Jul 12, 1913

7 BIRTHPLACE (City and State or Foreign Country): Oldham England

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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): St Anthonys Hospital

9c CITY TOWN OR LOCATION OF DEATH: Crown Point

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Mary Mayne Barbuch

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Adminstration Asst.

12b KIND OF BUSINESS/INDUSTRY: Municipality

13a RESIDENCE—STATE: Lowell In

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Lowell In 46356

13d STREET AND NUMBER: 380 Commanche Dr.

13e ZIP CODE: 46356

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): Henry Hurst

19 MOTHER'S NAME (First Middle Maiden Surname): N/A

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Mayne Hurst

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 380 Commanche Dr. Lowell In 46356

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Sep 11, 1995 St. Edward's Cemetery

21c LOCATION—City or Town, State: Lowell, IN

22a EMBALMER'S NAME: Kenneth P. Sheets

22b EMBALMER'S LICENSE NO: FD08900045

23 WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Kenneth P. Sheets

24b LICENSE NUMBER (of Licensee): FD08900045

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, FD83006277, 604 E. Commercial Ave, Lowell, IN

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF)
b. CHF Decompensated

DUE TO (OR AS A CONSEQUENCE OF)
c. Cerebrovascular Accident

DUE TO (OR AS A CONSEQUENCE OF)
d. Diabetes Mellitus

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

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)

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

SEP 15 1995

M. D. Williams, M.D.
STATE HEALTH COMMISSIONER

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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: John Kencos M D

29c MEDICAL LICENSE NO: 0637265

29d DATE SIGNED (Month Day Year): 9/13/95

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. John Kencos, 9495 Keilman, St. John, IN 46373

31 HEALTH OFFICER'S SIGNATURE: M. D. Williams, M.D.

32 DATE FILED (Month Day Year): September 15, 1995

FILED

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.

SAM ORLICH
AUDITOR LAKE COUNTY

001504

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1