* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 248 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): CARL A. WHEELER, JR.
2. SEX: MALE
3a. TIME OF DEATH: 1:25 P M
3b. DATE OF DEATH (Month, Day, Yr): SEPTEMBER 12, 1996
4. *SOCIAL SECURITY NUMBER: 326-28-0097
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): AUGUST 16, 1934
7. BIRTHPLACE (City and State or Foreign Country): TERRE HAUTE, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: —
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): ST. CATHERINE'S HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: EAST CHICAGO
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): NOVENA DAVIDSON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): TRUCK DRIVER
12b. KIND OF BUSINESS/INDUSTRY: HAMMERSLEY TRUCKING
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 3220 E. 36TH AVENUE
13e. ZIP CODE: 46405
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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): CARL A. WHEELER
19. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL M. GALBERT

INFORMANT

20a. INFORMANT'S NAME (Type/Print): NOVENA WHEELER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3220 E. 36TH AVENUE, LAKE STATION, IN. 46405
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SEPTEMBER 16, 1996 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: RUSSELL A. KRAFT, JR.
22b. EMBALMER'S LICENSE NO: 29300105
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH# 83002080 701 E. 7TH STREET, HOBART, IN. 46342

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. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF)
b. Coronary Artery Occlusive disease
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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 related 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.: 01029381
29d. DATE SIGNED (Month, Day, Year): 9/17/96
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DEEPAK BHOJRAJ, M. D., 295 S. WISCONSIN, HOBART, INDIANA 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Rankovich
32. DATE FILED (Month, Day, Year): 9-18-96

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.

FILED SEP 25 1996 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 SEP 25 PM 2:56 MARGARET E. CLEVELAND RECORDER

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Key # 35-50-233-16

CS 9.00 9/18

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