

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2563-96

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

41763
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First Middle Last) RONALD KENNETH TRESSLER, JR.		2. SEX Male	3a. TIME OF DEATH 9:35PM	3b. DATE OF DEATH (Month Day Yr) August 9, 1996
4. SOCIAL SECURITY NUMBER 178-20-0590	5a. AGE - Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Sep 24, 1926
7. BIRTHPLACE (City and State or Foreign Country) INDIANA, PA	8a. WAS DECEDENT A U.S. VETERAN? No			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A		8c. PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) 3021 CLAY STREET		9b. CITY TOWN OR LOCATION OF DEATH LAKE STATION	9c. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) EVELYN ALICE GLUTTING	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) OPERATING ENGINEER		12b. KIND OF BUSINESS INDUSTRY FURNACE MAINTENANCE
13a. RESIDENCE - STATE IN	13b. COUNTY LAKE	13c. CITY TOWN OR LOCATION LAKE STATION	13d. STREET AND NUMBER 3021 CLAY STREET	
13e. ZIP CODE 46405	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5		18. FATHER'S NAME (First, Middle, Last) RONALD K. TRESSLER, SR.		
19. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE HAAS		20a. INFORMANT'S NAME (Type/Print) EVELYN ALICE TRESSLER		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 CLAY STREET, LAKE STATION, IN 46405		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Aug 12, 1996 Calvary Cemetery		21c. LOCATION - City or Town Portage, IN
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FD01006483	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth P. Stowers</i>		24b. LICENSE NUMBER (of Licensee) FDO8900027	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83005613 Rees Funeral Home, Olson Chapel 5341 Central Avenue, Portage, IN 46368	
26. PART I - THIS CERTIFIES THAT THE ABOVE IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH OFFICE. IMMEDIATE CAUSE (Final disease or condition resulting in death) Myocardial Infarction		27. PART II - Other medical conditions, conditions contributing to death but not previously stated in Part I. Myocardial Infarction		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No
29a. 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 <i>Daniel B. Hurwich, MD</i>		
29c. MEDICAL LICENSE NO. 664262		29d. DATE SIGNED (Month Day Year) 8/25/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) DANIEL B. HURWICH, MD, 8895 BROADWAY, Merrillville, IN 46410				32. DATE FILED (Month Day Year) August 15, 1996
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Felling, MD</i>				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <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. 000263		



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STATE OF INDIANA
LAKE COUNTY HEALTH OFFICE
RECORDED
FILED FOR FILING
OCT - 3 AM '96

21-75-13