

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

STATE OF INDIANA
LAKE COUNTY
INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0596-95 96067200 CAUSE OF DEATH 96 OCT -9 AM 9:48

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-11-13

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

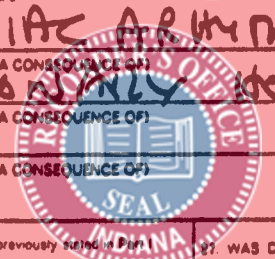
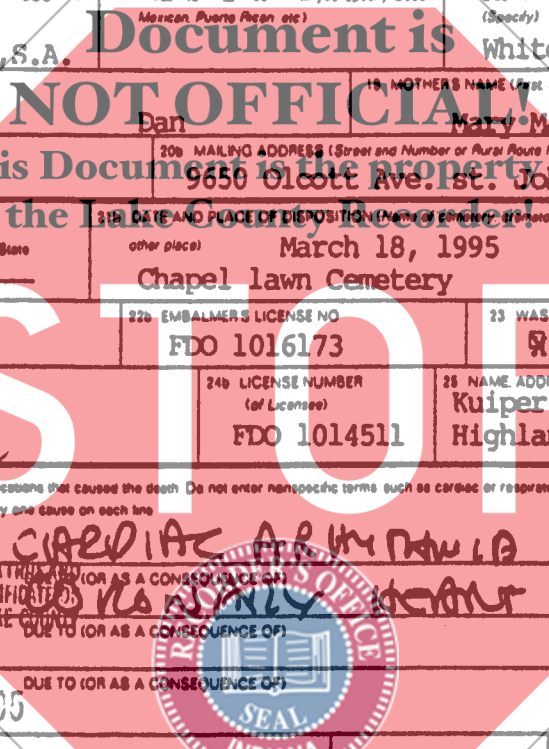
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) VICTOR DAN, Sr.		2 NAME OF DECEASED MARGARET LEE OLSON		3 DATE OF DEATH (Month Day Yr) MARCH 15, 1995	
4 SOCIAL SECURITY NUMBER 313-14-0942		5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Sep. 6, 1924
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana		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) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL			9b CITY TOWN OR LOCATION OF DEATH MUNSTER		9c COUNTY OF DEATH LAKE
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Lottie Bach		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor	
12b KIND OF BUSINESS/INDUSTRY Manufacturing		13a RESIDENCE—STATE Indiana		13b COUNTY Lake	
13c CITY TOWN OR LOCATION St. John		13d STREET AND NUMBER 9650 Olcott Ave.			
13e ZIP CODE 46373		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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) 12		18 FATHER'S NAME (First Middle Last) Theodor Dan			
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Maier		20a INFORMANT'S NAME (Type/Print) Lottie Dan		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 9650 Olcott Ave. St. John, Indiana 46373	
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)		21b DATE AND PLACE OF DISPOSITION (Date of death, if different, or other place) March 18, 1995 Chapel lawn Cemetery	
21c LOCATION—City or Town, State Schererville, Indiana		22a EMBALMER'S NAME Edgar Gleim		22b EMBALMER'S LICENSE NO. FDO 1016173	
23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511	
24c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500		25 PART I Enter the definite 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. CARDIAC ARRHYTHMIA			
25 PART II IMMEDIATE CAUSE (Final disease or condition resulting in death) HEALTH DEPT		25 PART III THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. DUE TO (OR AS A CONSEQUENCE OF)			
25 PART IV CONDITIONS OF ANY NATURE TO THE IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE (List)		26 PART V OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not previously stated in Part I DISCRETE MYELIOMATOSIS			
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)	
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>[Signature]</i>		29c MEDICAL LICENSE NO. 27468	
29d DATE SIGNED (Month Day Year) MARCH 15, 1995		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. GEORGE ASTERIS, M.D. 2450 169TH STREET HAMMOND, INDIANA 46323			
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, M.D.</i>		32 DATE FILED (Month Day Year) March 15, 1995			
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 000000			
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			



1st read
12-66-78
Candace
to file 17

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