

Kathy Beckman, 7895 Bway, Merrillville 46410

ATTENTION ESTATE: The Social Security # is being requested by the 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. 3035-96

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

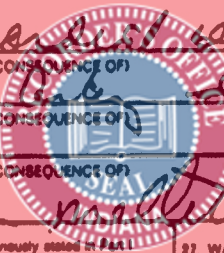
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) VIRGINIA MADELYN DAMPTZ				2 SEX Female	3a TIME OF DEATH 2:13 a.m.	3b DATE OF DEATH (Month Day Year) October 17, 1996
4 SOCIAL SECURITY NUMBER 347-01-5498		5a AGE—Last Birthday (Years) 89	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) April 2, 1907	7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? --	9 PLACE OF DEATH (Check only one) (See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
10 FACILITY NAME (If not institution, give street and number) Lutheran Home of Northwest Indiana			11a CITY, TOWN OR LOCATION OF DEATH Crown Point		11b COUNTY OF DEATH Lake	
12 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife, give maiden name) --	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sales Lady			12b KIND OF BUSINESS/INDUSTRY Department Store	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Crown Point		13d STREET AND NUMBER 1200 E. Luther Drive		
13e ZIP CODE 46307	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 11 College (1-4 or 5+)	
18 FATHER'S NAME (First Middle Last) James T. Dwyer			18 MOTHER'S NAME (First Middle Modern Surname) Elizabeth Cagney			
20a INFORMANT'S NAME (Type/Print) Joseph G. Damptz			20b ADDRESS (Street, Rural Route, P.O. Box, Number, City or Town, State, Zip Code) 2601 W. 61st Pl, Merrillville, IN 46410		20c Relationship Son	
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) October 21, 1996 Calvary Cemetery			21c LOCATION—City or Town Evanston, Illinois	
22a EMBALMER'S NAME Thomas G. Pruzin		22b EMBALMER'S LICENSE NO. 1009893		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL HOME REPRESENTATIVE <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 1009893		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME PRUZIN & LITTLE FUNERAL SERVICE #83001261 811 E. Franciscan Dr., Crown Point, IN 46307		
26 PART I Enter the disease, injuries, or combinations that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line. OCT 22 1996 <i>Myocardial infarction</i> due to (or as a consequence of) <i>arteriosclerosis</i> due to (or as a consequence of) <i>Diabetes mellitus</i> due to (or as a consequence of)						
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>cardiac arrhythmia, coronary artery disease, senescent degeneration of myocardium, etc.</i>						
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no			28. WAS AN AUTOPSY PERFORMED? (Yes or no) no		29. WERE A COPY OF THIS CERTIFICATE AVAILABLE FOR THE COMMISSION ON CAUSE OF DEATH? (Yes or no) no	
29a CERTIFIER (Check any 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> Arthur J. Beckman M.D.			29c MEDICAL LICENSE NO. 21432		29d DATE SIGNED (Month Day Year) 10-17-96	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Arthur J. Beckman M.D., 1211 S. Indiana Ave., Crown Point, IN 46307						
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32 DATE FILED (Month Day Year) October 21, 1996	
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		33a DATE OF INJURY (Month Day Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)	33d DESCRIBE HOW INJURY OCCURRED	
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)			34b 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, bicyclist, etc. no				

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 OCT 20 1996

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