Rev # 27-375-10

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2269-93 — **CERTIFICATE OF DEATH** — State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): C. John Nuss, Jr.
2 SEX: Male
3a TIME OF DEATH: 3:20 P.M.
3b DATE OF DEATH (Month Day Yr): September 22, 1993
4 SOCIAL SECURITY NUMBER: 405-50-3444
5a AGE—Last Birthday (Years): 55
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): Feb. 26, 1938
7 BIRTHPLACE (City and State or Foreign Country): Greenville, Ky.
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US 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): The Community Hospital
9c CITY TOWN OR LOCATION OF DEATH: Munster
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Mary Anne Sciotto
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Technical manager
12b KIND OF BUSINESS/INDUSTRY: Oil Refinery
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Highland
13d STREET AND NUMBER: 9324 4th St.
13e ZIP CODE: 46322
13f INSIDE CITY LIMITS [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 8; College (1-4 or 5+): 4

PARENTS

18 FATHER'S NAME (First Middle Last): Clovis John Nuss, Sr.
19 MOTHER'S NAME (First Middle Maiden Surname): Virginia Lovell

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary Anne Nuss
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 9324 4th Street Highland, Indiana
20c RELATIONSHIP: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 25, 1993 Concordia Cemetery
21c LOCATION—City or Town State: Hammond, Indiana
22a EMBALMER'S NAME: Ronald A. Reed
22b EMBALMER'S LICENSE NO: FDO 1001081
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9033 Kleinman Rd Highland, Indiana FDH 300-7500

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 brain death 1993
DUE TO (OR AS A CONSEQUENCE OF): b intracerebral hemorrhage
Conditions if any which gave rise to the immediate cause stating the underlying cause last: c
DUE TO (OR AS A CONSEQUENCE OF): d

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): 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): [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: [signature] MD
29c MEDICAL LICENSE NO: 23340
29d DATE SIGNED (Month Day Year): 9/13/93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARC A. LEVIN, M.D. 5500 HOHMAN AVENUE, SUITE 2A HAMMOND, INDIANA 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month Day Year): September 24, 1993

CORONER USE ONLY

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
FEB 10 1997
SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD FEB 13 PM 12:29 JOHN S. W. CARTER RECORDER

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