Local No. 2462-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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): Reid Charles Biederstadt
2. SEX: Male
3a. TIME OF DEATH: 5:00 A.M.
3b. DATE OF DEATH (Month, Day, Yr): October 13, 1993
4. SOCIAL SECURITY NUMBER: 347-22-0863
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Sep. 25, 1930
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1956
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Lowell Health Care Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Lowell
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Pearl Mitchell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Dispatcher
12b. KIND OF BUSINESS/INDUSTRY: Indiana Bell
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Lowell
13d. STREET AND NUMBER: 15511 Colfax
13e. ZIP CODE: 46356
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Frank Biederstadt
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Pearl Biederstadt
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15511 Colfax, Lowell, Indiana 46356
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 16, 1993 German Methodist Cemetery
21c. LOCATION—City or Town, State: Cedar Lake, Indiana
22a. EMBALMER'S NAME: Fred Oparka
22b. EMBALMER'S LICENSE NO.: FD01016076
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Fred Oparka
24b. LICENSE NUMBER (of Licensee): FD01016076
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Eller Brady FH83000825 Cedar Lake, Indiana 46303

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF)
b. Coronary Artery 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

Approximate Interval Between Onset and Death

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): 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.: 02001002
29d. DATE SIGNED (Month, Day, Year): 10-15-93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Richard J. Kreisat D.O. 2068 Lucas Parkway, Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): Oct 19, 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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 18 1997

SAM ORLICH
AUDITOR LAKE COUNTY

000737

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
97 FEB 18 AM 10:02
MORRIS W. CARTER RECORDER

97009842

LAKE COUNTY HEALTH COMMISSIONER

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1