

* ATTENTION ESTATE: The Social Security # is being requested by this 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

11/21/1997
Date Issued - Hammond Health Commissioner

Local No. 244

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

35-160-1

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Conrad A. Luzer		2 SEX Male		3a TIME OF DEATH 1:15 a		3b DATE OF DEATH (Month Day Year) March 29, 1997	
4 SOCIAL SECURITY NUMBER 354-34-4892		5a AGE—Last Birthday (Year) 75		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6a WAS DECEDENT A US VETERAN? No		6b YEAR LAST SERVED IN US ARMED FORCES? -		6c DATE OF BIRTH (Month Day Year) Feb. 13, 1922		7 BIRTHPLACE (City and State or Foreign Country) Antioch, Illinois	
8a PLACE OF DEATH (Check only one box) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				8b 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) St. Margaret Mercy Hospital				9b CITY, TOWN OR LOCATION OF DEATH Hammond		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Barbara Wisler		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Owner		12b KIND OF BUSINESS/INDUSTRY Construction	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 4515 Towle Avenue	
13e ZIP CODE 46327		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g ON A FARM? <input checked="" type="checkbox"/> No <input 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) College (13-16 or 17+) 8			
18 FATHER'S NAME (First Middle Last) Andrew Luzer				19 MOTHER'S NAME (First Middle, Maiden Surname) Mary Kerkovic			
20a INFORMANT'S NAME (Type/Print) Barbara Luzer		20b PLACING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Towle Avenue, Hammond, IN 46327		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"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 1, 1997 St. Edward Cemetery		21c LOCATION—City or Town, State Lowell, Indiana			
22a EMBALMER'S NAME Keith D. Anthony		22b EMBALMER'S LICENSE NO. 01011911		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR Keith D. Anthony		24b LICENSE NUMBER (of Licensee) 01011911		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, IN 46327			
26 PART I Enter the disease, 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) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		Chronic Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF) Pulmonary Emphysema DUE TO (OR AS A CONSEQUENCE OF)				APPROXIMATE INTERVAL BETWEEN DEATH AND RECORDING DATE OF INDIANA COUNTY RECORD FOR RECORDING MORRIS W. C. RECORDER ST. JOHNS HOSPITAL MAY 2 1997	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Pneumonia Gastrointestinal Bleeding		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b WERE AUTOPSY RECORDS 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 D. Lee		29c MEDICAL LICENSE NO. 35185		29d DATE SIGNED (Month, Day, Year) 03-29-97	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) O. Lee, M. D. 800 State Line Avenue, Calumet City, Illinois 60409						32 DATE FILED (Month, Day, Year) MAR 31 1997	
31 HEALTH OFFICER'S SIGNATURE G. Orlich						32 DATE FILED (Month, Day, Year) MAR 31 1997	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <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)	
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d DESCRIBE HOW INJURY OCCURRED FINAL ACCEPTANCE FOR TRANSFER. APR 17 1997					
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, etc.					

SAM ORLICH
AUDITOR LAKE COUNTY

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