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

Local No. 27801-95

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): Wendell W. Goad
2. SEX: Male
3a. TIME OF DEATH: 5:50 A.M.
3b. DATE OF DEATH (Month Day Yr): April 5, 1995
4. SOCIAL SECURITY NUMBER: 314-09-7220
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day Yr): Oct. 26, 1917
7. BIRTHPLACE (City and State or Foreign Country): UNK Iowa
8a. WAS DECEDENT A US VETERAN? YES
8b. YEAR LAST SERVED IN US ARMED FORCES? 1946
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): 2527 E. Lake Shore Dr.
9c. CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marjorie Gray
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Attorney
12b. KIND OF BUSINESS/INDUSTRY: Self Employed
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 2527 E. Lake Shore Dr.
13e. ZIP CODE: 46307
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): ; College (1-4 or 5+): 5+

PARENTS

18. FATHER'S NAME (First Middle Last): James H. Goad
19. MOTHER'S NAME (First Middle Maiden Surname): Rosa Watts

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Wendell W. Goad, II
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33o Golfview Dr. Schererville, Indiana
Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 10, 1995 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO: FDO 1016173
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. [stamp: THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.] [signature]
24b. LICENSE NUMBER (of Licensee): fDO 10141511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83000500

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. ACUTE MYELOID LEUKEMIA
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.
Conditions, if any, which gave rise to immediate cause, stating the underlying cause last. Approximate Interval Between Onset and Death

[stamp: APR 07 1995] [signature] M.D. LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: MYELODYSPLASTIC SYNDROME

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. AUTOPSY PERFORMED? NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

[stamp: FILED APR 18 1995 MORRIS W. CARTER RECORDER]
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 18 AM 11 3 56
[stamp: SAM ORLICH AUDITOR LAKE COUNTY]
0024136

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: 01030107
29d. DATE SIGNED (Month Day Year): 4/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): D Bibara M.D. [illegible] East 84th ave Merrillville, In.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] Williams M.D.
32. DATE FILED (Month Day Year): April 7, 1995

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.

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K. Ck# 24985

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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