(6)

* 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

Local No. 100797 State No. .....

42640

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)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
John	J.	Pfeifer	Male	4:33A M	May 13, 1997

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
335-05-8882	93			JUN 29, 1903	St. John, IN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See Instructions)
No	N/A	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthony Medical Center	Crown Point	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Amelia Scheidt	Inspector Quality Control	Ford Motor Co.

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	St. John	11480 W. 93rd Ave.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46373	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	8	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Pfeifer	Mary E. Koch

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Amelia Pfeifer	11480 W. 93rd Ave., St. John, IN 46373	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	MAY 16, 1997 Chapel Lawn Memorial Gardens	Schererville, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
Marty Andersen	FD01005205	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (or Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Sam Orlich	FD09000013	FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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. Renal failure	Two
	b. Dehydration & Bladder outlet DUE TO (OR AS A CONSEQUENCE OF)	two mo.
Conditions, if any, which gave rise to the above cause (a), stating the underlying cause last.	c. Dehydration & urinal obstruction DUE TO (OR AS A CONSEQUENCE OF)	two mo.
	d. DUE TO (OR AS A CONSEQUENCE OF)	

FILED

JUN 04 1997

SAM ORLICH
AUDITOR LAKE COUNTY

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	No	N/A

CERTIFIER

29a. CERTIFIER: ☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
☐ MEDICAL EXAMINER 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
X JA Kamar	01027088	5/14/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Joseph A. Kacmar M.D., 123 N. Court Street, Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH LAKE COUNTY HEALTH DEPARTMENT. JUN 4, 1997

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				MAY 14 1997

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)
	Alexander S. Williams, M.D LAKE COUNTY HEALTH COMMISSIONER

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	000260

9.00

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

6040350