Local No. 328-88

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97066684 97 OCT 15 1:02 MORRIS W. CARTER RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST MIDDLE LAST: WILLIAM H. LONG, JR.
3 DATE OF DEATH (Mo Day Yr): FEB. 15, 1988
4 SOCIAL SECURITY NUMBER: 322-20-6264
5a AGE—Last Birthday (Years): 60
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Month Day Year): MAY 10, 1927
7 BIRTHPLACE (City and State or Foreign Country): Olney, Illinois
8 YEAR LAST SERVED IN US ARMED FORCES? 1946
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): THE COMMUNITY HOSPITAL
9c CITY TOWN OR LOCATION OF DEATH: MUNSTER
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS—Married Never Married Widowed Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Lorene Swinson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Mechanic
12b KIND OF BUSINESS/INDUSTRY: Steel Co.
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: GRIFFITH
13d STREET AND NUMBER: 4929 CALHOUN ST.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: N/A
13g ZIP CODE: 46319
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican etc.) ☒ No ☐ Yes Specify
15 RACE—American Indian, Black, White etc (Specify)
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+)

PARENTS

17 FATHER'S NAME (First Middle Last): William H. Long, Sr.
18 MOTHER'S NAME (First Middle Maiden Surname): Mary Barnes

INFORMANT

19a INFORMANT'S NAME (Type Print): Lorene Long
19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 4929 Calhoun Griffith, Indiana
19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 18, 1988 Chapel Lawn Cemetery
20c LOCATION—City or Town State: Schererville, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b LICENSE NUMBER (of Licensee): FDE1014511
22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH300-7500

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge death occurred at the time, date and place stated. Signature and Title: [signature] MD
23b LICENSE NUMBER: 21655
23c DATE SIGNED (Month Day Year): 2/16/88

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 7:52 P.M.
25 DATE PRONOUNCED DEAD (Month Day Year): FEB. 15, 1988
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

SEE INSTRUCTIONS — CAUSE OF DEATH

27 PART I Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying 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. Cardio-Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF) b. Arteriosclerotic Heart Disease, failure
DUE TO (OR AS A CONSEQUENCE OF) c. Generalized arteriosclerosis
Sequentially list conditions if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF) d.

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Diabetes mellitus, Cardiac Arrhythmia
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED OCT 15 1997 SAM ORLICH AUDITOR LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated
☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated
29b SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c LICENSE NUMBER: 21655
29d DATE SIGNED (Month Day Year): 2/16/88
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): FELICIANO E. JIMENEZ, M.D. 800 MAC ARTHUR BLVD. MUNSTER, IN. 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD
32 DATE FILED (Month Day Year): 2-17-88

CORONER OR MEDICAL EXAMINER 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)

000205

Unit #25 Key #43-253-9 Octave Genereaux Add lot 7

Unit #01 Key #39-359-39440 Kopelke Acres Lots 39 40

SBH06-004 State Form 10110 Rev 10/87 DEATH-PD 1

cs gw