

* 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

9452 - Van Buren
C.P. 46307
State No. Fred Hershberger

Local No. 267896

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

41832
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) JOHN LUTHER HERSHBERGER		2 SEX MALE	3a TIME OF DEATH 8:45 A.M.	3b DATE OF DEATH (Month Day Year) AUGUST 28, 1996
4 SOCIAL SECURITY NUMBER 309-14-5413	5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days 0 0	5c UNDER 1 DAY Hours Minutes 0 0	6 DATE OF BIRTH (Mo Day Yr) NOV. 26, 1920
7 BIRTHPLACE (City and State or Foreign Country) Bourbon, Indiana	8a WAS DECEDENT A U.S. VETERAN? no			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? no	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not mentioned, give street and number) THE COMMUNITY HOSPITAL		9c CITY TOWN OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ruby R. Seitzinger	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Surveyor Engineer	12b KIND OF BUSINESS/INDUSTRY U.S. Sheet & Tin Mill	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 7231 Howard Avenue	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12 College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) Fred F. Hershberger		
19 MOTHER'S NAME (First Middle Maiden Surname) Lorena C. Barth		20a INFORMANT'S NAME (Type/Print) R. Raydelle Hershberger		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7231 Howard Ave. Hammond, IN 46324		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) August 31, 1996 Memory Lane Memorial Park		21c LOCATION—City or Town, State Schererville, Indiana
22a EMBALMER'S NAME David McCoy		22b EMBALMER'S LICENSE NO. FDO8700581	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>J. D. C. Rust</i>		24b LICENSE NUMBER (of Licensee) FDO1013507	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323	
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 (The disease or condition resulting in death) Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF) Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF) Aug 29 1996 DUE TO (OR AS A CONSEQUENCE OF)				
PART II. Other significant conditions contributing to death but not previously stated in Part I. Myocardial infarction, Congestive heart failure, Chronic anemia, Severe emphysema				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) -		28a WAS AN AUTOPSY PERFORMED? (Yes or no) -		28b WERE ANY FINDINGS AVAILABLE TO COMPLETION OF DEATH? (Yes/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 <i>Pravin Gupta M.D.</i>		29c MEDICAL LICENSE NO. 39588
29d DATE SIGNED (Month Day Year) AUGUST 28, 1996		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PRAVIN GUPTA, M.D. 9054 COLUMBIA AVENUE MUNSTER, INDIANA 46321		
31 HEALTH OFFICER'S SIGNATURE <i>Alexander...</i>		32 DATE FILED (Month Day Year) August 29, 1996		
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		33a DATE OF INJURY (Month Day Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)
33d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) OCT 30 1997		33e DESCRIBE HOW INJURY OCCURRED FILED		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes/No) (pedestrian, etc.) AUDITOR LAKE COUNTY		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

unit # 26
Key # 32-84-12
Buena Vista Add S 1/2 lot 11 & lot 12 Block 7

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT 30 PM 1:11
MORRIS W. CENTER

FILED
OCT 30 1997
SAM ORLICH
AUDITOR LAKE COUNTY

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SU
001833
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