

* 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

State No.

Local No. 2444-97

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

41070
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Leo Quint		2 SEX Male	3a TIME OF DEATH 12:45A	3b DATE OF DEATH (Month Day, Yr) November 25, 1997	
4 SOCIAL SECURITY NUMBER 310-22-4992	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) July 27, 1928	
7 BIRTHPLACE (City and State or Foreign Country) Hammond, IN	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence			
9a FACILITY NAME (If not institution, give street and number) 9628 Crestwood		9b CITY TOWN OR LOCATION OF DEATH Munster	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Marion Bacon	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) President		12b KIND OF BUSINESS/INDUSTRY Auto Parts	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Munster	13d STREET AND NUMBER 9628 Crestwood		
13e ZIP CODE 46321	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? 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 12 College (1-4 or 5 +) --		18 FATHER'S NAME (First Middle Last) Max Quint			
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Mark			20a INFORMANT'S NAME (Type/Print) Marion Quint		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9628 Crestwood Munster, IN 46321		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) November 27, 1997 NW IN Crematory		21c LOCATION—City or Town, State Crown Point, IN	
22a EMBALMER'S NAME None		22b EMBALMER'S LICENSE NO. None	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) 1021590	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321		
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. Metastatic Rectal Cancer a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.					
26 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 AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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 			
29c MEDICAL LICENSE NO. 01040756		29d DATE SIGNED (Month, Day, Year) Dec. 1, 1997			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Jano, 7905 Calumet Munster, IN 46321					
31 HEALTH OFFICER'S SIGNATURE Alexander S. Williams, MD DATE FILED (Month, Day, Year) November 1, 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)	34d DESCRIBE HOW & WHERE OCCURRED. CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. DEC 1 1997 000180
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. Alexander S. Williams, MD LAKE COUNTY HEALTH COMMISSIONER			

FILED

DEC 6 1997

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

SAMOBlich
AUDITOR LAKE COUNTY

28-261-32

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