ICCa

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

Local No. 2053-97

42095

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

Field	Entry
1. DECEASED-NAME (First Middle Last)	WILBERT H. WIRTZ
2. SEX	Male
3a. TIME OF DEATH	2:20PM
3b. DATE OF DEATH (Month Day Yr)	October 3, 1997
4. SOCIAL SECURITY NUMBER	307-30-3184
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)	Feb 23, 1920
7. BIRTHPLACE (City and State or Foreign Country)	Crown Point, Indiana
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES	N/A
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)	807 Franklin Street
9c. CITY TOWN OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Patricia J. Metts
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Plumber
12b. KIND OF BUSINESS INDUSTRY	Plumbing
13a. RESIDENCE - STATE	Indiana
13b. COUNTY	Lake
13c. CITY TOWN OR LOCATION	Hobart
13d. STREET AND NUMBER	807 Franklin Street
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN?	☒ 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)	12
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Joseph H. Wirtz
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Barbara Backe

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Patricia J. Wirtz
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	807 Franklin Street, Hobart, IN 46342
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	Oct 7, 1997 Hanna Cemetery
21c. LOCATION - City or Town State	Hanna, Indiana
22a. EMBALMER'S NAME	James J. Krause
22b. EMBALMER'S LICENSE NO.	FDO1006463
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road Hobart, IN 46342

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	COPD	years
DUE TO (OR AS A CONSEQUENCE OF) b.		
Conditions if any which gave rise to the immediate cause stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

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	No

FILED DEC 15 1997 SAM ORLICH AUDITOR LAKE COUNTY

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	R. Devanathan M.D
29c. MEDICAL LICENSE NO	01040141
29d. DATE SIGNED (Month Day Year)	10/6/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Raja Devanathan MD, 1400 S. Lake Park Avenue, Suite 405, Hobart, IN 46342

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD
32. DATE FILED (Month Day Year)	October 6, 1997

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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.	

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY

OCT 06 1997

00095

9.00

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD DEC 15 3:00

Earle + Davis Add All Lots 1+2 Bl 31 Key # 17-120-1

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1