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

Local No. 078A-96

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

1 DECEASED—NAME (First, Middle, Last): MARIAN H. BISSING
2 SEX: FEMALE
3a TIME OF DEATH: 12:25 A M
3b DATE OF DEATH (Month, Day, Yr): APRIL 16,1996
4 *SOCIAL SECURITY NUMBER: 106-01-9726
5a AGE—Last Birthday (Years): 80
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): DEC.5, 1915
7 BIRTHPLACE (City and State or Foreign Country): BUFFALO NEW YORK
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 ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 631 S. Court Street
9c CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Eugene B Bissing
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Bookkeeper
12b KIND OF BUSINESS/INDUSTRY: Carroll Chevrolet Yuche Country Club
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Crown Point
13d STREET AND NUMBER: 631 S. Court
13e ZIP CODE: 46307
13f INSIDE CITY LIMITS? ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.A
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

18 FATHER'S NAME (First, Middle, Last): HARRY L HUNT
19 MOTHER'S NAME (First, Middle, Maiden Surname): RUTH LA SEUR

INFORMANT

20a INFORMANT'S NAME (Type/Print): EUGENE B BISSING
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 S.COURT ST, CROWN POINT, IN 46307
20c RELATIONSHIP: HUSBAND

DISPOSITION

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): APRIL 18,1996 IND.UNIVERSITY SCHOOL OF MEDICINE
21c LOCATION—City or Town, State: INDIANAPOLIS, INDIANA
22a EMBALMER'S NAME: GORDON L JONES
22b EMBALMER'S LICENSE NO: 1010711
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James E Burns
24b LICENSE NUMBER (of Licensee): 1009461
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home,10101 Broadway Crown Point,IN 46307 FDH83002445

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Respiratory Failure — Approximate Interval Between Onset and Death: 1-2 Days
DUE TO (OR AS A CONSEQUENCE OF): b. Recurrence of the Lung Ca — 2 1/2 months
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Brain + Carcinoma - 8/95

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

FILED APR 15 1996

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, 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

SAM ORLICH AUDITOR LAKE COUNTY

29b SIGNATURE AND TITLE OF CERTIFIER: JH Kacmar M.D.
29c MEDICAL LICENSE NO: 0102705
29d DATE SIGNED (Month, Day, Year): 4/17/96

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Joseph Kacmar, 123 N. Court, Crown Point, IN 46307
31 HEALTH OFFICER'S SIGNATURE: J.D. Kacmar MD
32 DATE FILED (Month, Day, Year): April 17, 1996

#9-354-13 + 43

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

000970

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

STATE OF INDIANA LAKE COUNTY RECORD