

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2575-92

CERTIFICATE OF DEATH

State No.

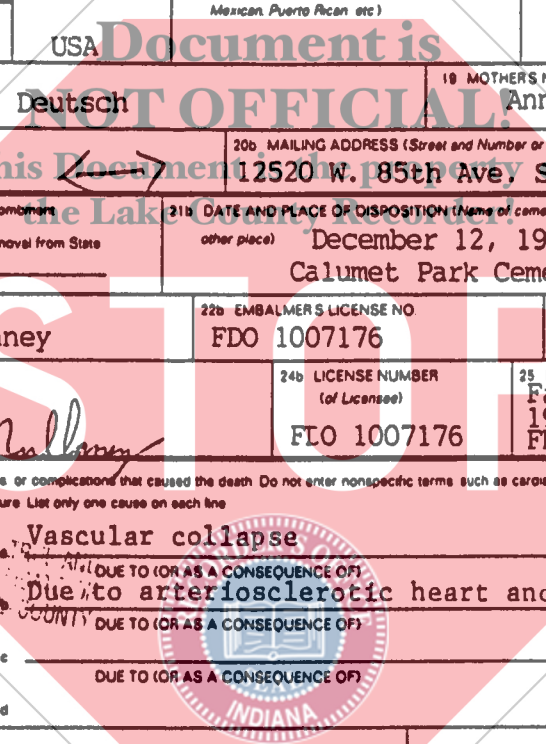
THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER I.C. 16-1-4-3

STATE OF INDIANA
LAKE COUNTY

FILED FOR RECORD

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Walter A. Deutsch		2 SEX Male	3a TIME OF DEATH 10:20 A.M.	3b DATE OF DEATH (Month, Day, Yr.) December 10, 1992	
4 SOCIAL SECURITY NUMBER 8024679b97	5a AGE—Last Birthday (Years) 49	5b UNDER 1 YEAR 1 Months Day	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) March 24, 1943	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1965	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) St Margaret Mercy South Hospital		9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mary Ann Wirtz	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Tester	12b KIND OF BUSINESS/INDUSTRY Steel Co		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION St. John	13d STREET AND NUMBER 12520 W. 85th Ave.		
13e ZIP CODE 46373	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) White	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (1-4 or 5) 3		18 FATHER'S NAME (First, Middle, Last) Adolph H. Deutsch			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Annie Dax		20a INFORMANT'S NAME (Type/print) Mary Ann Deutsch			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12520 W. 85th Ave, St John, Indiana 46373		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) December 12, 1992 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Edward F. Mullaney		22b EMBALMER'S LICENSE NO. FDO 1007176	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>		24b LICENSE NUMBER (of Licensee) FLO 1007176	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens Inc. 1920 Hart St. Dyer, Indiana 46311 FH83001504		
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. Approximate Interval Between Onset and Death Unknown					
THIS DEATH WAS CAUSED BY: Vascular collapse					
DUE TO (OR AS A CONSEQUENCE OF) Due to arteriosclerotic heart and vascular disease					
DUE TO (OR AS A CONSEQUENCE OF) DEC 11 1992					
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) 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) -			
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 checked="" 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>Deborah Huseman</i> Chief Deputy			
29c MEDICAL LICENSE NO. N/A		29d DATE SIGNED (Month, Day, Yr.) December 11, 1992			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) Deborah Huseman, Chief Deputy Coroner, 2293 North Main Street, Crown Point, IN 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>					
32 DATE FILED (Month, Day, Year) December 11, 1992					
33 MANNER OF DEATH <input checked="" 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)	
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) December 10, 1992		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger, pedestrian, etc.			



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

unit #09
Key # 11-9M-34
Acres lot 33 + E 50ft of lot 32
St John
Pon & Co's

FILED

SAM ORLICH

AUDITOR LAKE COUNTY 00099