10cc

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

Local No. 0327-98

200619

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

1. DECEASED - NAME (First, Middle, Last): GEORGE L EKLUND
2. SEX: Male
3a. TIME OF DEATH: 7:04 PM
3b. DATE OF DEATH (Month, Day, Yr.): February 12, 1998
4. *SOCIAL SECURITY NUMBER: 306-09-4086
5a. AGE - Last Birthday (Years): 82
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): January 21,1916
7. BIRTHPLACE (City and State or Foreign Country): MICHIGAN CITY INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [x] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
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): GLADYS E MORFEE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): PRODUCTION PLANNING
12b. KIND OF BUSINESS/INDUSTRY: U.S. STEEL (RETIRED)
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HOBART
13d. STREET AND NUMBER: 1534 MAPLE STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [x] Yes
13g. ON A FARM?: [x] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [x] 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+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): GEORGE F EKLUND
19. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE DABBERT

INFORMANT

20a. INFORMANT'S NAME (Type/Print): GLADYS E. EKLUND
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1534 MAPLE STREET, HOBART, IN 46342
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [x] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 16, 1998 N.W. INDIANA CREMATION SERVICES
21c. LOCATION - City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: Russell A. Kraft
22b. EMBALMER'S LICENSE NO.: 29300105
23. WAS DEATH REPORTED TO CORONER?: [x] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P. Burns
24b. LICENSE NUMBER (of Licensee): FD1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebrovascular accident
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

FILED

APR 20 1998

SAM ORLICH

AUDITOR LAKE COUNTY

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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U): 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): —

CERTIFIER

29a. CERTIFIER (Check only one)
[x] 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.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 01035122
29d. DATE SIGNED (Month, Day, Year): 2/17/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. SHARON HARIG 8895 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Williams M.D.
32. DATE FILED (Month, Day, Year): February 17, 1998

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): February 12, 1998
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

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

FEB 17 1998

Alejandro S. Williams M.D.

LAKE COUNTY HEALTH COMMISSIONER

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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

98 APR 20 PM 10:

State Form 10110 (R4/3-93) Deathcor/PD 1

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STOP

RECORDER'S OFFICE SEAL INDIANA