20+2 FA 23834

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2478-93

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

HOLD FOR FIRST AMERICAN TITLE

DECEDENT

1 DECEASED—NAME (First Middle Last): Paul R. Mance

2 SEX: Male

3a TIME OF DEATH: 8:20A.M

3b DATE OF DEATH (Month Day Yr): October 20, 1993

4 SOCIAL SECURITY NUMBER: 354-26-6622

5a AGE—Last Birthday (Years): 59

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo Day Yr): August 23, 1934

7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinoi

8a WAS DECEDENT A U S VETERAN?: Yes

8b YEAR LAST SERVED IN U S ARMED FORCES?: 1961

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): 725 Newcastle Dr.

9c CITY TOWN OR LOCATION OF DEATH: Schererville

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife give maiden name): Geraldine Reano

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Salesman

12b KIND OF BUSINESS/INDUSTRY: Refractory Mfgr.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Schererville

13d STREET AND NUMBER: 725 Newcastle Dr.

13e ZIP CODE: 46375

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 +): 2

PARENTS

18 FATHER'S NAME (First Middle Last): Edward Mance

19 MOTHER'S NAME (First Middle Maiden Surname): Gertrude Wegner

INFORMANT

20a INFORMANT'S NAME (Type/Print): Geraldine Mance

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 725 Newcastle Dr. Schererville, IN

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): October 23, 1993 Holy Cross Cemetery

21c LOCATION—City or Town State: Calumet City, IL

22a EMBALMER'S NAME: Daniel Holste

22b EMBALMER'S LICENSE NO: IL 034-014638

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FDO 1018769

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: [illegible] Hammond IN FDH 3002851 722 165th for Schroeder-Lauer 3227 Ridge Rd. Lansing, IL

CAUSE OF DEATH

28 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. [illegible] Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF)

b. [illegible]

DUE TO (OR AS A CONSEQUENCE OF)

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

c. [illegible]

DUE TO (OR AS A CONSEQUENCE OF)

d.

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 PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

APR 2 - 1993

SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED

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

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c MEDICAL LICENSE NO: 36-42573

29d DATE SIGNED (Month Day Year): 10-21-93

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Richard S Krowski 1400 Torrence Calumet City Il 60409

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D

32 DATE FILED (Month Day Year): October 22, 1993

CORONER USE ONLY

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

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SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER-PD 1

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