

* 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

CERTIFICATE OF DEATH

Donald Orlich
P.O. Box 128

State No. ... Lowell 40256..

Local No. ... 0838-98

256604
TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-37

DECEDENT

PARENTS

INFORMANT

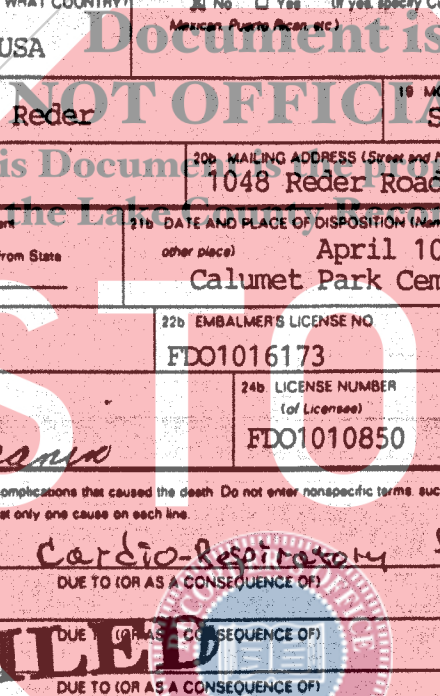
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Sylvester J. Reder		2. SEX male	3a. TIME OF DEATH 10:05A_M	3b. DATE OF DEATH (Month, Day, Year) April 6, 1998	
4. SOCIAL SECURITY NUMBER 316-05-5216	5a. AGE—Last Birthday (Year) 77	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo., Day, Yr) January 17, 1921	
7. BIRTHPLACE (City and State or Foreign Country) Griffith, Indiana	8a. WAS DECEDENT A U.S. VETERAN? yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? not available	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) St. Anthony Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Crown Point	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) married	11. SURVIVING SPOUSE (If wife, give maiden name) Dorothy Perkins	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Boiler Maker	12b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Local Union		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Griffith	13d. STREET AND NUMBER 1048 Reder Road		
13e. ZIP CODE 46319	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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. FATHER'S NAME (First, Middle, Last) Jacob Reder		18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Maas			
20a. INFORMANT'S NAME (Type/Print) Dorothy Reder		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1048 Reder Road Griffith, Indiana 46319		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) April 10, 1998 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Rigar C. Gleim		22b. EMBALMER'S LICENSE NO. FDO1016173		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James Blacinski</i>		24b. LICENSE NUMBER (of License) FDO1010850		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Road Highland Indiana 46322 FHB3007500	
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. Cardio-respiratory failure DUE TO (OR AS A CONSEQUENCE OF)			THIS CERTIFICATE IS THE COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.		
b. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. APR 07 1998					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. MAY 26 1998					
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	
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 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>Troy W. Stovall MD</i>			29c. MEDICAL LICENSE NO. 02001581		
29d. DATE SIGNED (Month, Day, Year) 4/7/98					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Troy W. Stovall, D.O., 9430 Wicker, St. John, IN. 46373					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Stovall MD</i>				32. DATE FILED (Month, Day, Year) April 7, 1998	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. NO			



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