

* 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

State No.

Hold For: Gladys McNair

Local No. 1441-98

265136

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Doris M. Bruckman		2 SEX Female	3a TIME OF DEATH 11:44P M	3b DATE OF DEATH (Month, Day, Yr) June 22, 1998	
4 SOCIAL SECURITY NUMBER 317-20-8522	5a AGE—Last Birthday (Year) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) JUN 2, 1925	
7 BIRTHPLACE (City and State or Foreign Country) Crown Point, In.	8a WAS DECEDENT A US VETERAN? No		8b YEAR LAST SERVED IN US ARMED FORCES? N/A		
9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA		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. Anthony Medical Center		9c CITY, TOWN OR LOCATION OF DEATH Crown Point	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wid. give maiden name) NONE	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cashier		12b KIND OF BUSINESS/INDUSTRY Restaurant	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Crown Point		13d STREET AND NUMBER 300 Hoffman St.	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) <input checked="" type="checkbox"/> College (1-4 or 5+)		17 12			
18 FATHER'S NAME (First, Middle, Last) Walter Westphal		19 MOTHER'S NAME (First, Middle, Maiden Surname) Zella Hershman			
20a INFORMANT'S NAME (Type/Print) Susan Bruckman		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 300 Hoffman St., Crown Point, In 46307		20c Relationship Daughter	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) JUN 26 1998 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Ray White		22b EMBALMER'S LICENSE NO. FD08700086		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Raymond E. White</i>		24b LICENSE NUMBER (of Licensee) FD08700086		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FHB3001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307	
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. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF)					
b. _____ DUE TO (OR AS A CONSEQUENCE OF)					
c. _____ DUE TO (OR AS A CONSEQUENCE OF)					
Conditions if any which gave rise to the immediate cause bearing the underlying cause list					
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 REQUIRED? (Yes or no) No			
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		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.		SAM ORLICH AUDITOR LAKE COUNTY			
<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>[Signature]</i>		29c MEDICAL LICENSE NO. 01039302	29d DATE SIGNED (Month, Day, Year) June 23, 1998		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Bernardo S. Lucena M. D., 1121 S. Indiana Ave., Crown Point, IN 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>			32 DATE FILED (Month, Day, Year) June 24, 1998		
33 MANNER OF DEATH <input 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)	34d DESCRIBE HOW INJURY OCCURRED
34a 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.			

006001 [Signature]