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* 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.

Local No. ... 0536-97

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

43378
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

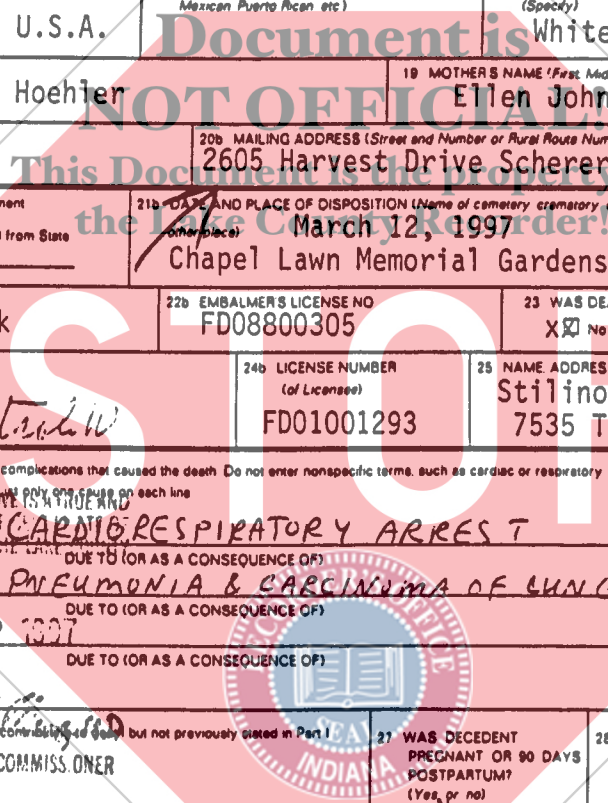
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Otto F. Hoehler		2 SEX Male	3a TIME OF DEATH 7:30 P	3b DATE OF DEATH (Month Day Yr) March 8, 1997
4 SOCIAL SECURITY NUMBER 046-18-7016	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) April 9, 1925
7 BIRTHPLACE (City and State or Foreign Country) Stamford, Connecticut	8a WAS DECEDENT A US VETERAN? yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input 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) Methodist Southlake South Campus		9c CITY, TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife give maiden name) Blanche Kirschenheiter	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Plant Foreman	12b KIND OF BUSINESS, INDUSTRY Manufacturing	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Scherverville	13d STREET AND NUMBER 2605 Harvest Drive	
13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12	18 FATHER'S NAME (First Middle, Last) Otto Hoehler	19 MOTHER'S NAME (First Middle, Maiden Surname) Ellen Johnson		17a ELEMENTARY/SECONDARY (0-12) 17b COLLEGE (1-4 or 5+)
20a INFORMANT'S NAME (Type, Print) Blanche Hoehler		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Harvest Drive Scherverville, In 46375		20c Relationship Wife
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) March 12, 1997 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Scherverville, Indiana
22a EMBALMER'S NAME Leonard Gregorczyk		22b EMBALMER'S LICENSE NO (of Licensee) FD08800305	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert W. ...</i>		24b LICENSE NUMBER (of Licensee) FD01001293	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Stilnovich & Wiatolik FH83004455 7535 Taft St. Merrillville, In 46410	
26 PART I Enter the diseases, injuries or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory. Enter only one cause on each line. COMPLETE COPY OF THIS CERTIFICATE TO BE FILED IN THE COUNTY HEALTH DEPARTMENT. IMMEDIATE CAUSE (disease or condition resulting in death) HEALTH DEPT CARDIORESPIRATORY ARREST PNEUMONIA & CARCINOMA OF LUNG MAR 12 1997 DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions (Conditions contributing to death but not previously stated in Part I) LAKE COUNTY HEALTH COMMISS. ONER				
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) 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 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 of death.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Zabaneh M D</i>		29c MEDICAL LICENSE NO C1033620
29d DATE SIGNED (Month Day Year) 3-7-97		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Dr. I Zabaneh 6111 Harrison Street Merrillville Suite 215 46410 980-4242		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month Day Year) March 12, 1997		
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? FILED
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home farm street, factory, office building, etc (Specify) SEP 4		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 902
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc SAM ORLICH AUDITOR LAKE COUNTY 000492		



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98 SEP 10

STATE HEALTH DEPT

unit #20
Key # 13-532-2
Spring Harvest Condos Unit 2605 Harvest Dr