* **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.

Local No. 1932-98

269946

# 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**

| Field | Entry |
|---|---|
| 1 DECEASED—NAME (First Middle Last) | Jacob G. Witzke |
| 2 SEX | Male |
| 3a TIME OF DEATH | 1:05A M |
| 3b DATE OF DEATH (Month Day Yr) | August 30, 1998 |
| 4 *SOCIAL SECURITY NUMBER | 304-14-8330 |
| 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) | June 1, 1916 |
| 7 BIRTHPLACE (City and State or Foreign Country) | Chicago, IL |
| 8a WAS DECEDENT A U.S. VETERAN? | No |
| 8b YEAR LAST SERVED IN U.S. ARMED FORCES? | None |
| 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) | 10623 Manor Drive |
| 9c CITY, TOWN OR LOCATION OF DEATH | St. John |
| 9d COUNTY OF DEATH | Lake |
| 10 MARITAL STATUS (Specify) | Married |
| 11 SURVIVING SPOUSE (If wife, give maiden name) | Betty M. Hathaway |
| 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | Machinist |
| 12b KIND OF BUSINESS/INDUSTRY | Vermette Machine Co. |
| 13a RESIDENCE—STATE | Indiana |
| 13b COUNTY | Lake |
| 13c CITY, TOWN OR LOCATION | St. John |
| 13d STREET AND NUMBER | 10623 Manor Dr., |
| 13e ZIP CODE | 46373 |
| 13f INSIDE CITY LIMITS | ☐ No ☒ Yes |
| 13g ON A FARM? | ☒ No ☐ Yes |
| 14 CITIZEN OF WHAT COUNTRY? | USA |
| 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | ☒ No ☐ Yes |
| 16 RACE—American Indian, Black, White, etc. (Specify) | White |
| 17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | 9 |
| College (1-4 or 5+) | |

**PARENTS**

| Field | Entry |
|---|---|
| 18 FATHER'S NAME (First, Middle, Last) | Henry A. Witzke |
| 19 MOTHER'S NAME (First, Middle, Maiden Surname) | Olga Krueger |

**INFORMANT**

| Field | Entry |
|---|---|
| 20a INFORMANT'S NAME (Type/Print) | Betty M. Witzke |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 10623 Manor Dr., St. John, IN 46373 |
| 20c Relationship | Wife |

**DISPOSITION**

| Field | Entry |
|---|---|
| 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) | September 2, 1998 Graceland Cemetery |
| 21c LOCATION—City or Town, State | Valparaiso, IN |
| 22a EMBALMER'S NAME | Henry J. Blake |
| 22b EMBALMER'S LICENSE NO. | FD01019406 |
| 23 WAS DEATH REPORTED TO CORONER? | ☒ No ☐ Yes |
| 24a SIGNATURE OF FUNERAL DIRECTOR | Ellen B LaHayne |
| 24b LICENSE NUMBER (of Licensee) | FD01000857 |
| 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME | LaHayne Funeral Home, Inc., FH19400005 6955 Southeastern Ave., Hammond, IN 4632- |

**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.

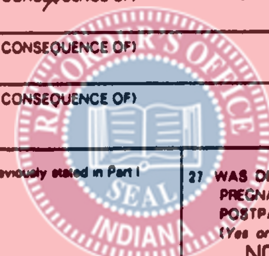
| | Cause | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) a | Non-Hodgkin's Lymphoma IV | 3 months |
| DUE TO (OR AS A CONSEQUENCE OF) b | | |
| DUE TO (OR AS A CONSEQUENCE OF) c | | |
| DUE TO (OR AS A CONSEQUENCE OF) d | | |

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

AUG 31 1998

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

| Field | Entry |
|---|---|
| 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 |



**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

| Field | Entry |
|---|---|
| 29b SIGNATURE AND TITLE OF CERTIFIER | [signature] |
| 29c MEDICAL LICENSE NO. | 01041301 |
| 29d DATE SIGNED (Month, Day, Year) | August 31, 1998 |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) | Cheryl L. Morgan-Ihrig, M.D., 1630 45th, Munster, IN 46321 |

**HEALTH OFFICER**

| Field | Entry |
|---|---|
| 31 HEALTH OFFICER'S SIGNATURE | Alexander S. Hillman, MD |
| 32 DATE FILED (Month, Day, Year) | August 31, 1998 |

| Field | Entry |
|---|---|
| 33 MANNER OF DEATH | ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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, etc. | |

FILED

SEP 8 1998

SAM ORLICH

AUDITOR LAKE COUNTY

000600

900

White Oak Manor 2nd Add Lot 29 Key #52-85-13 Un. #40

1660086

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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