* 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.

Key# 18-203-7

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

Local No. 1690-98 State No. ....

43561

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

TYPE/PRINT IN PERMANENT BLACK INK

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MORRIS W. CARTER RECORDER

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	JACK D. MUELLER
2. SEX	MALE
3a. TIME OF DEATH	10:40 A
3b. DATE OF DEATH (Month Day Yr)	JULY 23, 1998
4. SOCIAL SECURITY NUMBER	305-32-6069
5a. AGE—Last Birthday (Years)	60
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo. Day. Yr)	MAR. 4, 1938
7. BIRTHPLACE (City and State or Foreign Country)	MARISSA, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	33 N. ILLINOIS STREET
9c. CITY, TOWN, OR LOCATION OF DEATH	HOBART
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	SHARON L. FRAILEY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	YARD MANAGER
12b. KIND OF BUSINESS/INDUSTRY	CITY OF HOBART
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HOBART
13d. STREET AND NUMBER	33 N. ILLINOIS STREET
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
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)	12
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	FRANK MUELLER
19. MOTHER'S NAME (First, Middle, Maiden Surname)	ERNESTINE SCHOLEBO

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	SHARON L. MUELLER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	33 N. ILLINOIS ST., HOBART, IN 46342
20c. Relationship	WIFE

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	JULY 27, 1998 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State	MERRILLVILLE INDIANA
22a. EMBALMER'S NAME	GORDON L. JONES
22b. EMBALMER'S LICENSE NO.	1010711
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Gordon L. Jones
24b. LICENSE NUMBER (of Licensee)	1010711
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BURNS FUNERAL HOME, 701 E. 7TH STREET HOBART, IN 46342 83002380

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.	carcinoma of lung	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

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

27. WAS DECEDENT PREGNANT OR POSTPARTUM?	WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	N/A

PETER BENJAMIN LAKE COUNTY AUDITOR

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month Day Year)
[signature] MD	01020846	7/27/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. DONALD PHILLIPS, 1356 S. LAKE PARK AVE., HOBART, INDIANA

HEALTH OFFICER

31. SIGNATURE: Alexander Williams, MD

32. DATE FILED (Month Day Year): 8/5/98

CERTIFIED COMPLETE COPY LAKE COUNTY HEALTH DEPT.

33. MANNER OF DEATH	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)

AUG 05 1998

9.00 E.P.

34g. DATE PRONOUNCED DEAD (Month Day Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

001625

Alexander Williams MD
LAKE COUNTY HEALTH COMMISSIONER