14cc + 3 vets

* **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 OF INDIANA
LAKE
FILED FOR RECORD
RECORDER

Local No. 99-0725 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): ROBERT A. CRAIGIN 9908963
2 SEX: Male
3a TIME OF DEATH: 7:20 PM
3b DATE OF DEATH (Month, Day, Yr): October 13, 1999
4 *SOCIAL SECURITY NUMBER: 010-10-5081
5a AGE—Last Birthday (Years): 77
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): January 20, 1922
7 BIRTHPLACE (City and State or Foreign Country): Boston, Massachusetts
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
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): 7305 Oak Street
9c CITY, TOWN OR LOCATION OF DEATH: Miller
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Sarah Jane Geisen
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Safety Compliance Officer
12b KIND OF BUSINESS/INDUSTRY: OSHA
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hobart
13d STREET AND NUMBER: 3604 East 34th Lane
13e ZIP CODE: 46342
13f INSIDE CITY LIMITS? ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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); College (1-4 or 5+): 2

PARENTS

18 FATHER'S NAME (First, Middle, Last): Frederick W. Craigin
19 MOTHER'S NAME (First, Middle, Maiden Surname): Nellie M. (Ellen) Geran

INFORMANT

20a INFORMANT'S NAME (Type/Print): Sarah Jane Craigin
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3604 E. 34th Lane Hobart, Indiana 46342
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): October 18, 1999 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Ronald J. Mesarch
22b EMBALMER'S LICENSE NO: FD01005912
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: William C. Geisen
24b LICENSE NUMBER (of Licensee): FD01003203
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Benign Prostatic Hypertrophy — Approximate Interval Between Onset and Death:
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

FILED

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I
27 WAS DECEDENT PREGNANT OR WITHIN 12 MONTHS 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

OCT 28 1999

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) and manner 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: Birute Pumputis
29c MEDICAL LICENSE NO: 01032738
29d DATE SIGNED (Month, Day, Year): 10-15-99

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Birute L. Pumputis, M.D. 320 West 61st Avenue Hobart, Indiana 46342
31 HEALTH OFFICER'S SIGNATURE: Birute L. Pumputis M.D.
32 DATE FILED (Month, Day, Year): OCT 19 1999

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY occurred: 21812
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): 9.00
34g DATE PRONOUNCED DEAD (Month, Day, Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
E.P. CS

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