INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 4678-89 | State No. ....

2000 010709

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	CARL A. ZICKUHR
2 SEX	MALE
3a TIME OF DEATH	2:5 p/m
3b DATE OF DEATH (Month Day Yr)	NOVEMBER 22, 1989
4 SOCIAL SECURITY NUMBER	317-09-3611
5a AGE—Last Birthday (Years)	75
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo. Day Yr)	MAY 30, 1914
7 BIRTHPLACE (City and State or Foreign Country)	MILWAUKEE, WISCONSIN
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. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	LUTHERAN HOME OF NORTHWEST INDIANA, INC.
9c CITY, TOWN, OR LOCATION OF DEATH	CROWN POINT
9d COUNTY OF DEATH	LAKE COUNTY
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name)	GENEVIEVE M. MITSCH
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	ROLLER
12b KIND OF BUSINESS/INDUSTRY	US STEEL
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN, OR LOCATION	HOBART
13d STREET AND NUMBER	1332 EAST CLEVELAND
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? (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) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	HENRY A. ZICKUHR
19 MOTHER'S NAME (First, Middle, Maiden Surname)	ELIZABETH LOPPNOW

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	GENEVIEVE M. ZICKUHR
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1332 EAST CLEVELAND, HOBART, IN 46342
20c Relationship	SPOUSE

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)	NOVEMBER 25, 1989 MAPELWOOD CEMETERY
21c LOCATION—City or Town, State	CROWN POINT, INDIANA
22a EMBALMER'S NAME	JAMES W. GHOLSTON
22b EMBALMER'S LICENSE NO	FD01004194
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Gerald Rees
24b LICENSE NUMBER (of Licensee)	FD01041083
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	REES FUNERAL HOME, INC. FDH3003069 600 WEST RIDGE ROAD, HOBART, IN 46342

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. CARDIAC ARREST
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

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

Field	Entry
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	NO
28a WAS AN AUTOPSY PERFORMED?	NO
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	N/A

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	01035185
29d DATE SIGNED (Month, Day, Year)	11-28-89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	O.J. LEE, MD, 800 STATE LINE AVENUE, CALUMET CITY, ILLINOIS 60409

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature]
32 DATE FILED (Month, Day, Year)	Nov 29, 89

CORONER USE ONLY

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.	

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Law office - Kenneth L. Fugate - 7553 Ridge Rd. Hobart, In. 46342

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STOP
FILED
FEB 11 2000
PETER BENJAMIN LAKE COUNTY AUDITOR
NOV 29 1989
THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
LAKE COUNTY HEALTH COMMISSIONER