(1)

INDIANA STATE BOARD OF HEALTH

Local No. 884-89   2000 010841   CERTIFICATE OF DEATH   2000 FEB 10 AM 9 07   State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Henry E. Raschke
2. SEX	Male
3. DATE OF DEATH (Mo. Day Yr.)	April 11, 1989
4. SOCIAL SECURITY NUMBER	359-05-2083
5a. AGE—Last Birthday (Years)	79
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Month, Day, Year)	Feb.3,1910
7. BIRTHPLACE (City and State or Foreign Country)	Chicago, Illinois
8. 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 ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	1712 Center Street
9c. CITY, TOWN, OR LOCATION OF DEATH	Whiting
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	Married
11. SURVIVING SPOUSE (If wife give maiden name)	Mary T. Seketa
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Packaging
12b. KIND OF BUSINESS/INDUSTRY	Container Company
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Whiting
13d. STREET AND NUMBER	1712 Center Street
13e. INSIDE CITY LIMITS? (Yes or no)	Yes
13f. FARM	No
13g. ZIP CODE	46394
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify	NO
15. RACE—American Indian, Black, White, etc. (Specify)	White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Unavailable

PARENTS

Field	Entry
17. FATHER'S NAME (First, Middle, Last)	Anthony Raschke
18. MOTHER'S NAME (First, Middle, Maiden Surname)	Barbara Devorak

INFORMANT

Field	Entry
19a. INFORMANT'S NAME (Type/Print)	Mary T. Raschke
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1712 Center Street Whiting, IN 46394
19c. Relationship	Wife

DISPOSITION

Field	Entry
20a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	April 14, 1989 St. John Cem.
20c. LOCATION—City or Town, State	Hammond, IN
21a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
21b. LICENSE NUMBER (of Licensee)	FDE1008643
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	RUZICH FUNERAL HOME 727 2031 Indianapolis Blvd. Whiting, IN4639

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title

23b. LICENSE NUMBER

23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Field	Entry
24. TIME OF DEATH	700 AM
25. DATE PRONOUNCED DEAD (Month, Day, Year)	April 11, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER?	

CAUSE OF DEATH — SEE INSTRUCTIONS

27. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): CARDIOPULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF): COLON CANCER

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER — SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	E. Gailani [signature]
29c. LICENSE NUMBER	01033342
29d. DATE SIGNED (Month, Day, Year)	4/20/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)	DR. Gailani 7905 Calumet Ave. Munster Ind.

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature]
32. DATE FILED (Month, Day, Year)	4-20-89

CORONER OR MEDICAL EXAMINER USE ONLY

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)

SBH06-004 State Form 10110 (R/10-87) DEATH A/PO 1

Stamps and annotations:

I CERTIFY THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

William M. Williams 2 MD, LAKE COUNTY HEALTH COMMISSIONER

JAN 28 2000

FILED FEB 15 2000

PETER BENJAMIN LAKE COUNTY AUDITOR

BURNETT TITLE

KT# 25-121-14

2000 003065T

Keane Fetz 4/15