

STATE OF INDIANA 11-281-30  
LAKE COUNTY  
FILED DEATH RECORD

\* 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

Local No. 2782-99 2000 01 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

PARENTS

INFORMANT

DISPOSITION

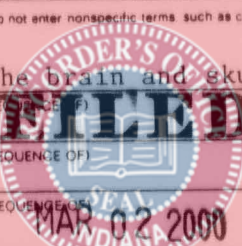
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Todd P. Musgrave		2 SEX Male	3a TIME OF DEATH 9:01A M	3b DATE OF DEATH (Month Day Yr) December 6, 1999	
4 *SOCIAL SECURITY NUMBER 311-82-3674	5a AGE—Last Birthday (Years) 36	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Nov. 20, 1963	7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana
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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 6325 W. 89th Avenue		9c CITY TOWN OR LOCATION OF DEATH Crown Point		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Leslie Hughes	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Operator		12b KIND OF BUSINESS/INDUSTRY P&H Iron Supply	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Crown Point		13d STREET AND NUMBER 6325 W. 89th Ave.	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) White	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 12
18 FATHER'S NAME (First Middle Last) Larry Musgrave		19 MOTHER'S NAME (First Middle Maiden Surname) Donna Buchanan			
20a INFORMANT'S NAME (Type/Print) Leslie Musgrave		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6325 W. 89th Ave. Crown Point, IN		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 9, 1999 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Schererville, Indian	
22a EMBALMERS NAME Edgar C. Gleim		22b EMBALMER'S LICENSE NO. FD01016173		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald C. Lee</i>		24b LICENSE NUMBER (of Licensee) FD01001081		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home FH83007500 9039 Kleinman Rd. Highland, IN	
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 Laceration of the brain and skull fracture DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I 27 WAS DECEDENT LAME, WAS AN AUTOPSY PERFORMED? (Yes or no) N/A Yes 28 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes					
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. Deputy <input checked="" type="checkbox"/> 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 <i>Mitchell Oglego</i>		29c MEDICAL LICENSE NO. N/A		29d DATE SIGNED (Month Day Year) December 8, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Mitchell Oglego, Deputy Coroner, 2000 West 9th Avenue, Crown Point, Indiana 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>				32 DATE FILED (Month Day Year) December 8, 1999	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year) Dec 6, 1999	34b TIME OF INJURY Unknown	34c INJURY AT WORK? (Yes or no) No	34d DESCRIBE HOW INJURY OCCURRED Gunshot wound 9:00 8P 5
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Residence/Basement		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 6325 West 89th Avenue Crown Point, Indiana 46307			
34g DATE PRONOUNCED DEAD (Month Day Year) December 6, 1999		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No 530			

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DEC 09 1999