* 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.

Local No. 07784-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 2000 016 635

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): MARIAN H. BISSING	2. SEX: FEMALE	3a. TIME OF DEATH: 12:25 A M	3b. DATE OF DEATH (Month, Day, Yr): APRIL 16,1996
4. *SOCIAL SECURITY NUMBER: 106-01-9726	5a. AGE—Last Birthday (Years): 80	5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo. Day, Yr): DEC.5, 1915
7. BIRTHPLACE (City and State or Foreign Country): BUFFALO NEW YORK			
8a. WAS DECEDENT A U.S. VETERAN?: NO	8b. YEAR LAST SERVED IN US ARMED FORCES?: N/A	9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XX Residence	
9b. FACILITY NAME (If not institution, give street and number): 631 S. Court Street	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): Eugene B Bissing	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Bookkeeper	12b. KIND OF BUSINESS/INDUSTRY: Carroll Chevrolet Yuche Country Club
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Crown Point	13d. STREET AND NUMBER: 631 S. Court
13e. ZIP CODE: 46307	13f. INSIDE CITY LIMITS ☐ No ☒ Yes; 13g. ON A FARM? ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: U.S.A.A	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): 12; College (1-4 or 5+):		

PARENTS

18. FATHER'S NAME (First, Middle, Last): HARRY L HUNT	19. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH LA SEUR

INFORMANT

20a. INFORMANT'S NAME (Type/Print): EUGENE B BISSING	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 S.COURT ST, CROWN POINT, IN 46307	20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☐ Cremation ☐ Removal from State ☒ XX Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 18,1996 IND.UNIVERSITY SCHOOL OF MEDICINE	21c. LOCATION—City or Town, State: INDIANAPOLIS, INDIANA
22a. EMBALMER'S NAME: GORDON L JONES	22b. EMBALMER'S LICENSE NO: 1010711	23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns	24b. LICENSE NUMBER (of Licensee): 1009461	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445

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. Respiratory Failure — Approximate Interval Between Onset and Death: 1-2 Days
DUE TO (OR AS A CONSEQUENCE OF)
b. Carcinoma of the lung — ≈18 months
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.

A TRUE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
APR 15 1998
[signature] MD
LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Breast Carcinoma - 8/95

27. WAS DECEDENT PREGNANT OR 90 DAYS 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): N/A

CERTIFIER

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred 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: J.A. Kacmar, M.D.	29c. MEDICAL LICENSE NO: 01027088	29d. DATE SIGNED (Month, Day, Year): 4/17/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Joseph Kacmar, 123 N. Court, Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], MD

32. DATE FILED (Month, Day, Year): April 17, 1996

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.		

9.00 Fee

9768 14142

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

MARC H. Donaldson
101 N. Main St. Crown Point, In. 46307

FILED
PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

25 X 10