William O'Connor
8817 Woodward
Highland In. 46322

STATE OF INDIANA

LaGRANGE COUNTY CERTIFICATE OF DEATH

2000 016525 2000 MAR -9 AM 8:57

1 DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Leonard E. Balon	MORRIS W. OAR	Male	9:40P M	June 16 1994

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
314-26-8962	63			July 19,1930	East Chicago, IN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1952	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Vencor Hospital LaGrange	LaGrange	LaGrange

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Elizabeth Sandor	Store Room Manager	Municipal-City Gov

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	East Chicago	4112 Fir St.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46312	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Anton Balon	Helen Szafraniec

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Elizabeth Balon	4112 Fir St.,East Chicago,IN 46312	Wife

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	June 19, 1994 Central Michigan Crematory	Battle Creek, MI

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
No Embalming	N/A	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Jon R. Thornton	FDO 8600694	Frurip-May F.H. FH 83003988 309 W. Mich.,LaGrange,IN 46761

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. ✓Cardiopulmonary Arrest	✓Time
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF) Arteriosclerotic heart Disease	
	c. DUE TO (OR AS A CONSEQUENCE OF) COPD	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I.	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Diabetes	No	No	N/A

29a. CERTIFIER (Check only one)

- [X] 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.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
✓ M. Reed Taylor	01019129	June 17,1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
M. Reed Taylor, M.D., 0080 - 600 N, Howe, IN 46746

FILED

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
MAR 08 2000	6-17-94

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY Ooccurred
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

34e. PLACE OF INJURY—At home, farm, street, factory, building etc. (Specify)	34f. LOCATION (Address 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.

PETER BENJAMIN
LAKE COUNTY AUDITOR

9.00
7.5
3617

THIS IS AN OFFICIAL COPY OF THE RECORD OF DEATH ON FILE AT THE LaGRANGE COUNTY HEALTH DEPARTMENT:
LOCAL HEALTH OFFICER

25x