Key # 3-82-16
3-82-17

* **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. 132

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE, COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

State Date Issued FEB 7 2000 Hammond Health Commission

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): Hildegard Niefanger
2 SEX: Female
3a TIME OF DEATH: 2:25 PM
3b DATE OF DEATH (Month Day Yr): February 5, 2000
4 *SOCIAL SECURITY NUMBER: 321-26-4810
5a AGE—Last Birthday (Years): 80
5b UNDER 1 YEAR Months Days: 15
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): Jan.8,1920
7 BIRTHPLACE (City and State or Foreign Country): Amberg, Germany
8a WAS DECEDENT EVER A U.S. VETERAN? No
8b 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 ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution give street and number): St. Margaret Mercy Healthcare
9c CITY TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Francis X.Niefanger
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Home
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Lowell
13d STREET AND NUMBER: 525 S. Lakeview Dr.
13e ZIP CODE: 46356
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? U.S.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): Henry Nachreiner
19 MOTHER'S NAME (First Middle Maiden Surname): Clara Spate

INFORMANT

20a INFORMANT'S NAME (Type/Print): Marlene Briggs
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 17807 W. 66th Ave. Tinley Pk., IL 60477
20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): February 10 ,2000 Woodlawn Crematory
21c LOCATION—City or Town State: Forest Park, IL
22a EMBALMER'S NAME: George Dominiak
22b EMBALMER'S LICENSE NO: 034-010674
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#300281 5840 Hohman Hammond,IN(For Han F.H./Bridgeview,IL Signature Only)

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

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. CARDIO-PULMONARY COLLAPSE
DUE TO (OR AS A CONSEQUENCE OF)
b ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause stating the underlying cause last
c ATHEROSCLEROTIC HEART DISEASE
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 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): --

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
29b SIGNATURE AND TITLE OF CERTIFIER: D.O.
29c MEDICAL LICENSE NO: X02001056
29d DATE SIGNED (Month Day Year): Feb. 9 ,2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print): Mark Rybczynski, D.O. 9167 Wicker St.John, IN 46373

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Brenner M.D.
FILED
32 DATE FILED (Month Day Year): February 9 2000

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)
PETER BENJAMIN
LAKE COUNTY AUDITOR
34g DATE PRONOUNCED DEAD (Month Day Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

9.00 cash 900

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