

ATTENTION STATE: 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.

STATE OF INDIANA  
 INDIANA STATE DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH  
 FILED FOR RECORD  
 MAR 7 2000  
 Date Issued  
 Hammond Health Commission

Local No. .... 202 .....

2000 018037

2000 MAR 16

TYPE/PRINT  
 IN  
 PERMANENT  
 BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

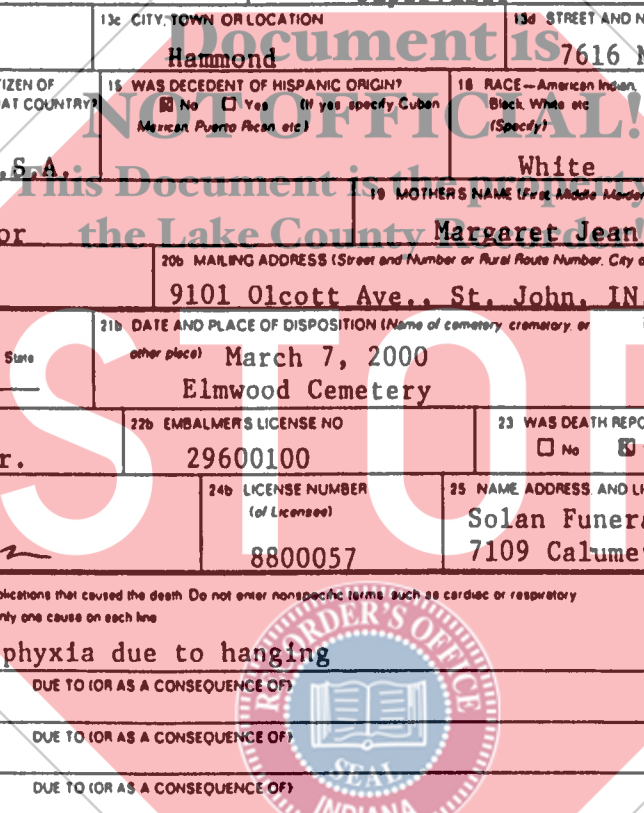
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>WALLACE L. HECTOR</b>		2 SEX <b>Male</b>		3a TIME OF DEATH <b>3:55 P.M.</b>		3b DATE OF DEATH (Month Day Year) <b>March 2, 2000</b>	
4 *SOCIAL SECURITY NUMBER <b>314 50 8456</b>		5a AGE—Last Birthday (Years) <b>44</b>		5b UNDER 1 YEAR Months Days <b>March 2, 1956</b>		5c UNDER 1 DAY Hours Minutes <b>3:55 P.M.</b>	
6a WAS DECEDENT A U.S. VETERAN? <b>NO</b>		6b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		6c PLACE OF BIRTH (Month Day Year) <b>March 2, 1956</b>			
6d YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		6e PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)				6f BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>	
9b FACILITY NAME (If not institution give street and number) <b>7616 Magnolia Avenue</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Hammond</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Never Married</b>		11 SURVIVING SPOUSE (If wife give maiden name) <b>N/A</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Supervisor</b>		12b KIND OF BUSINESS/INDUSTRY <b>Federal Cement</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>Hammond</b>		13d STREET AND NUMBER <b>7616 Magnolia Avenue</b>	
13e ZIP CODE <b>46324</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian Black White etc (Specify) <b>White</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>			
18 FATHER'S NAME (First Middle Last) <b>Wallace C. Hector</b>				19 MOTHER'S NAME (First Middle Maiden Surname) <b>Margaret Jean Caldwell</b>			
20a INFORMANT'S NAME (Type/Print) <b>Joyce L. Berdine</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9101 Olcott Ave., St. John, IN, 46373</b>				20c Relationship <b>Sister</b>	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>March 7, 2000 Elmwood Cemetery</b>				21c LOCATION—City or Town, State <b>Hammond, Indiana</b>	
22a EMBALMER'S NAME <b>John S. Pruzin, Jr.</b>		22b EMBALMER'S LICENSE NO. <b>29600100</b>		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean L. Wagner</i>		24b LICENSE NUMBER (of Licensee) <b>8800057</b>		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN, 46324</b>			
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) <b>Asphyxia due to hanging</b>						<b>Unknown</b>	
a DUE TO (OR AS A CONSEQUENCE OF)							
b DUE TO (OR AS A CONSEQUENCE OF)							
c DUE TO (OR AS A CONSEQUENCE OF)							
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) <b>No</b>				28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>Yes</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>Yes</b>	
29a CERTIFIER (Check only one) <b>Deputy</b>		<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		<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) as stated	
29b SIGNATURE AND TITLE OF CERTIFIER <i>Franklin J. Bremer de la...</i>				29c MEDICAL LICENSE NO. <b>N/A</b>		29d DATE SIGNED (Month Day Year) <b>March 7, 2000</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Peter Benjamin...</i>				32 DATE FILED (Month Day Year) <b>MAR 15 2000</b>			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year) <b>March 2, 2000</b>		34b TIME OF INJURY <b>Unknown</b>		34c INJURY AT WORK? (Yes or no) <b>No</b>	
		34d DESCRIBE HOW INJURY OCCURRED <b>Hanging</b>		34e PLACE OF INJURY—At home farm street factory office building etc (Specify) <b>Residence/Basement</b>			
		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>7616 Magnolia Street Hammond, IN</b>					
34g DATE PRONOUNCED DEAD (Month Day Year) <b>March 2, 2000</b>				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc <b>No.</b>			

Lot 34 of 35 Bldg 5 Resub Jackson Terrace PB 18 Page 4



**FILED**

**PETER BENJAMIN  
 LAKE COUNTY AUDITOR**

**01091**