* **ATTENTION ESTATE:** Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 2547-99

268893

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. #36-180-7

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED–NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
KENNETH W. HALAS	Male	4:45PM	November 9, 1999

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)
307-42-9567	57			Jul 22, 1942	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	1966	HOSPITAL ☒ 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
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

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	SHARON CRIST	SCARFER	INLAND STEEL

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	LAKE	HAMMOND	424 176TH COURT

13e. ZIP CODE	13f. INSIDE CITY LIMITS	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)	
					Elementary/Secondary (0-12)	College (1-4 or 5+)
46324	13g. ON A FARM? ☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	12	—

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN HALAS	HELEN SZYNDROWSKI

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
SHARON HALAS	424 176TH COURT, HAMMOND, IN 46324	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION - City or Town State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Nov 13, 1999 ST.JOHN-ST.JOSEPH CATHOLIC	HAMMOND

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
C. WILLIAM MCCOY	FDO1013612	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
George L. Bocken	FDO1042047	FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, HAMMOND, IN 46323

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. Acute Myocardial Infarction	
	b. DUE TO (OR AS A CONSEQUENCE OF)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	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 PREGNANT WITHIN THE LAST YEAR? 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)
	No	No	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	29c. LICENSE NO	29d. DATE SIGNED (Month Day Year)
P. Makam	PETER BENJAMIN LAKE COUNTY AUDITOR	Nov 11, 1999

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
PRAKASH MAKAM, MD., 9123 COLUMBIA AVE., MUNSTER, IN 46321

31. HEALTH OFFICER'S SIGNATURE Alexander S. Williams, M.D.

32. DATE FILED (Month Day Year) November 12, 1999

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 OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				ONE COPY OF THIS CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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)
	NOV 12 1999

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.
	Alexander S. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

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