8CC'S + VETS

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 3087-96 State No. .....

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): LEWIS K. RETTIG
2 SEX: MALE
3a TIME OF DEATH: 2:40 PM
3b DATE OF DEATH (Month Day Yr): OCTOBER 25, 1996
4 SOCIAL SECURITY NUMBER: 342-14-9317
5a AGE—Last Birthday (Years): 73
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): OCT. 8, 1923
7 BIRTHPLACE (City and State or Foreign Country): FINDLEY, ILLINOIS
8a WAS DECEDENT A U S VETERAN?: YES-US ARMY
8b YEAR LAST SERVED IN US ARMED FORCES?: 1946
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): 225 S. VIRGINIA
9c CITY TOWN OR LOCATION OF DEATH: HOBART
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife give maiden name): VIRGINIA BURLEIGH
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): MASTER MECHANIC
12b KIND OF BUSINESS/INDUSTRY: HOWELL TRACTOR AND EQUIPMENT COMPANY
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 225 S. VIRGINIA
13e ZIP CODE: 46342
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): SAMUEL FRANKLIN RETTIG
19 MOTHER'S NAME (First Middle Maiden Surname): HELEN MARIE KEIM

INFORMANT

20a INFORMANT'S NAME (Type/Print): VIRGINIA D. RETTIG
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 225 S. VIRGINIA, HOBART, INDIANA 46342
20c Relationship: WIFE

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): OCTOBER 29, 1996 EVERGREEN MEMORIAL PARK
21c LOCATION—City or Town State: HOBART, INDIANA
22a EMBALMER'S NAME: GORDON L. JONES
22b EMBALMER'S LICENSE NO: 01010711
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James F. Burns
24b LICENSE NUMBER (of Licensee): 01009461
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH#83002380 701 E. 7TH STREET, HOBART, IN. 46342

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

FILED

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. CHRONIC AND Cancer of Lung — DUE TO (OR AS A CONSEQUENCE OF): b. [illegible] — 4yrs

Conditions if any which gave rise to the immediate cause stating the underlying cause last:
DUE TO (OR AS A CONSEQUENCE OF): c. [illegible]
DUE TO (OR AS A CONSEQUENCE OF): d. [illegible]

PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II Other significant conditions Conditions contributing to death but not previously stated in Part I: [illegible] CORONER

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: Mark D Carter
29c MEDICAL LICENSE NO: 36056415
29d DATE SIGNED (Month Day Year): 10/28/96

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARK CARTER, M. D., 295 S. WISCONSIN, HOBART, INDIANA 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month Day Year): October 30, 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 Ooccurred: 020516
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): 9 Com Cook
34g DATE PRONOUNCED DEAD (Month Day Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

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