* **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. 240 6.9.19.0

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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

MAR 21, 2000 Date Issued — Franklin D Brenneda Hammond Health Commissione

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)
2000 022811	OSTERMAN, SR.	MALE	9:30P M	MARCH 17, 2000

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)
316-30-1716	66			SEPT. 29, 1933	HAMMOND, INDIANA

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)
NO	N/A	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
ST. MARGARET MERCY HEALTHCARE CENTER/	HAMMOND	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	EVELYN H. KRISTEK	MAINTENANCE PAINTER	ST. MARGARET HOSP

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND (WHITING P.O.)	1720 DAVIS AVENUE

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) Elementary/Secondary (0-12)	College (1-4 or 5+)
46394	☐ No ☒ Yes	☒ 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)
CLARENCE OSTERMAN, SR.	ANN MARIE WINKLEI

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
MRS. EVELYN H. OSTERMAN	1720 DAVIS AVE., WHITING, IN 46394	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
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	MARCH 23, 2000 HERITAGE CREMATORY	PORTAGE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
MARTIN A. DYBEL	FDE01019456	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Martin A. Dybel	FDE01019456	BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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 RUPTURE - ABDOMINAL AORTIC ANEURYSM	HOURS
	DUE TO (OR AS A CONSEQUENCE OF)	
	b DIABETES	YEARS
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	c HYPERTENSION	YEARS
	DUE TO (OR AS A CONSEQUENCE OF)	
	d	

FILED APR 03 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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

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 MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
	01001161	MARCH 18, 2000

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print)
CLAUDE A. FOREIT, D.O., 3831 HOHMAN AVENUE, HAMMOND, INDIANA 46327

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Franklin D Brenneda M.D.	March 21, 2000

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				

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)
	9.00

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