* **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.

H 62000 1171 LD

INDIANA STATE DEPARTMENT OF HEALTH

(2)

Local No. 1815-95

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	ROBERT RAY MAHNS
2 SEX	MALE
3a TIME OF DEATH	9:45 AM
3b DATE OF DEATH (Month, Day, Yr)	AUGUST 15, 1995
4 *SOCIAL SECURITY NUMBER	305-20-3587
5a AGE—Last Birthday (Years)	68
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo, Day, Yr)	Jan. 24, 1927
7 BIRTHPLACE (City and State or Foreign Country)	Hammond IN
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN U.S. 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)	1119 Azalea Dr.
9c CITY, TOWN OR LOCATION OF DEATH	Munster
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Beverly Funk
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Manager
12b KIND OF BUSINESS/INDUSTRY	NIPSCO
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Munster
13d STREET AND NUMBER	1119 Azalea Dr.
13e ZIP CODE	46321
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
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

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Raymond A. Mahns
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Elvera Beiriger

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Beverly Mahns
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1119 Azalea Dr. Munster, In 46321
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	August 18, 1995 Oakland Memory Lanes
21c LOCATION—City or Town, State	Dolton, IL
22a EMBALMER'S NAME	James Porras
22b EMBALMER'S LICENSE NO	1045964
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	1045184
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish Funeral Home#3004968 8415 Calumet Munster, In 46321

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPT.

AUG 16 1995

[signature] M.D.
LAKE COUNTY HEALTH COMMISSIONER

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

	Cause	Interval
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Severe Congestive Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF)	Dilated Cardiomyopathy	
DUE TO (OR AS A CONSEQUENCE OF)	Severe left Ventricular dysfunction	
DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Recurrent Ventricular Tachycardia; Severe Coronary Artery disease with prior Myocardial Infarction

Field	Entry
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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature] MD
29c MEDICAL LICENSE NO	40667
29d DATE SIGNED (Month, Day, Year)	AUGUST 16, 1995
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	DR. SHASHIDHAR DIVAKARUNI, M.D., 7905 CALUMET AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature] M.D.
32 DATE FILED (Month, Day, Year)	August 16, 1995

Field	Entry
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)	69232
34g DATE PRONOUNCED DEAD (Month, Day, Year)	
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	

9.00 9/94 CP

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

Margin notation: pt 20 Fairmeadow 19th add Plat Book 40 Page 105

2000 023388

FILED

APR 05 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA FILED FOR RECORD 2000 APR -5 AM 9:55