6cc

* 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. 99 0728

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. #41-262-5

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): Estelle M. Ohler

2 SEX: Female

3a TIME OF DEATH: 4:25 PM

3b DATE OF DEATH (Month Day Yr): October 14, 1999

4 *SOCIAL SECURITY NUMBER: 316-03-5453

5a AGE—Last Birthday (Years): 78

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo Day Yr): Sept.9,1921

7 BIRTHPLACE (City and State or Foreign Country): Gary, Indiana

8a WAS DECEDENT A U.S. VETERAN?: No

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A

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): 3837 E. 13th Avenue

9c CITY, TOWN OR LOCATION OF DEATH: Gary

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Widow

11 SURVIVING SPOUSE (If wife, give maiden name): None

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Head Waitress

12b KIND OF BUSINESS/INDUSTRY: Gary Country Club

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 3837 E. 13th Avenue

13e ZIP CODE: 46403

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): 11; College (1-4 or 5+): N/A

PARENTS

18 FATHER'S NAME (First Middle Last): William Belle

19 MOTHER'S NAME (First Middle Maiden Surname): Mary Stakevycius

INFORMANT

20a INFORMANT'S NAME (Type/Print): William Belle, Jr.

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1210 New Jersey St., Gary, IN 46403

20c Relationship: Brother

DISPOSITION

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): October 19, 1999 Evergreen Memorial Park

21c LOCATION—City or Town, State: Hobart Indiana

22a EMBALMER'S NAME: Gordon L. Jones

22b EMBALMER'S LICENSE NO: 1010711

23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: James E. Burns

24b LICENSE NUMBER (of Licensee): 1009461

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home, 701 E. 7th Street Hobart, IN 46342 FH83002380

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	Uncontrolled diabetes Mellitus	
b	DUE TO (OR AS A CONSEQUENCE OF)	
c	DUE TO (OR AS A CONSEQUENCE OF)	
d	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

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NG

28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: [signature]

29c MEDICAL LICENSE NO: 01032738

29d DATE SIGNED (Month Day Year): 10-19-99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Birute Pumputis, 1500 S. Lake Park Ave., Hobart, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD MPH

32 DATE FILED (Month Day Year): OCT 20 1999

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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)

34g DATE PRONOUNCED DEAD (Month Day Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, driver, passenger, pedestrian, etc.

FILED

APR 24 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

51303

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