* 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. 32

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Jan 12, 2000 — Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

2000 031941

FILED

DECEDENT

1. DECEASED—NAME (First Middle Last): Charles W. House
2. SEX: Male
3a. TIME OF DEATH: 7:55 p.m.
3b. DATE OF DEATH (Month Day Yr): January 07, 2000
4. SOCIAL SECURITY NUMBER: 489-14-9450
5a. AGE—Last Birthday (Years): 86
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo Day Yr): (Nov) 11/19/13
7. BIRTHPLACE (City and State or Foreign Country): Campbell, Missouri
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 ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution give street and number): 927 Spruce Street
9c. CITY, TOWN OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife give maiden name): Pansy Hayes
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Auto Mechanic
12b. KIND OF BUSINESS/INDUSTRY: Auto Repair
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 927 Spruce Street
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Sidney House
19. MOTHER'S NAME (First Middle Maiden Surname): Elzia Launis

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Pansy House
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 927 Spruce Street, Hammond, IN 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): January 11, 2000 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Robert P. Saul
22b. EMBALMER'S LICENSE NO: 29700098
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 29700098
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Chapel Lawn Funeral Home FH19900051 8178 Cline Ave., Schererville, IN 46375

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Congestive Heart Failure	6 months–1 yr
DUE TO (OR AS A CONSEQUENCE OF) b.	Coronary Artery Disease	
DUE TO (OR AS A CONSEQUENCE OF) c.	Atrial Fibrillation	
DUE TO (OR AS A CONSEQUENCE OF) d.		

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): 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): No

FILED MAY 10 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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: Hayssam Kadah
29c. MEDICAL LICENSE NO: 01039940 IN
29d. DATE SIGNED (Month Day Year): 1/12/2000 (January)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Hayssam Kadah, MD 9330 Broadway, Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Bermuda M.D.
32. DATE FILED (Month Day Year): January 12, 2000

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month Day Year): N/A
34b. TIME OF INJURY: N/A
34c. INJURY AT WORK? (Yes or no): N/A
34d. DESCRIBE HOW INJURY OCCURRED: N/A
34e. PLACE OF INJURY—At home, farm, street, factory, office building etc. (Specify): N/A
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A
34g. DATE PRONOUNCED DEAD (Month Day Year): N/A
34h. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes specify driver, passenger, pedestrian etc.: No

00747

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

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