2000-043395 Key# 35-357-14

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 952

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.

Nov. 26, 1996 — Date Issued — Hammond Health Commissioner

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)	Geraldine Maryann Hafner
2. Sex	Female
3a. Time of Death	12:30P.M.
3b. Date of Death (Month Day Yr)	November 21, 1996
4. Social Security Number	310-38-6357
5a. Age-Last Birthday (Years)	57
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo Day Yr)	Jan 25, 1939
7. Birthplace (City and State or Foreign Country)	Chicago, IL
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 ☒ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	7345 Marshall
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)	Donald E. Hafner
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Housewife
12b. Kind of Business Industry	Home
13a. Residence - State	IN
13b. County	Lake
13c. City Town or Location	Hammond
13d. Street and Number	7345 Marshall
13e. Zip Code	46323
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
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

Field	Entry
18. Father's Name (First, Middle, Last)	Tim McKenna
19. Mother's Name (First, Middle, Maiden Surname)	Irene Miller

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Donald E. Hafner
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7345 Marshall, Hammond, IN 46323
20c. Relationship	Husband

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)	Nov 25, 1996 Holy Cross Cemetery
21c. Location - City or Town State	Calumet City, Illinois
22a. Embalmer's Name	James W. Gholston
22b. Embalmer's License No.	1004194
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	1045362
25. Name Address and License Number of Funeral Home	3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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. PANCREATIC CANCER
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
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)	28a. Was an Autopsy Performed? (Yes or no)	28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
No	No	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 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)
ANN M. MAUER, M.D. [signature] MD	036-090420	NOV. 11/23/96

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): ANN M. MAUER 5841 S. MARYLAND AVE. MC 2115, CHICAGO IL 60637

HEALTH OFFICER

31. Health Officer's Signature: Franklin J. Bremuda M.D.
32. Date Filed (Month Day Year): NOV 26 1996

Field	Entry
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)	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 specify driver...	No

FILED June 2, 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR
01527

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PO 1

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