12

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. 1337-00

INDIANA STATE DEPARTMENT OF HEALTH

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

1. DECEASED—NAME (First, Middle, Last): RICHARD B. RAAB, SR.	2. SEX: MALE	3a. TIME OF DEATH: 8:50P.M	3b. DATE OF DEATH (Month, Day, Yr): June 5, 2000
4. SOCIAL SECURITY NUMBER: 310-48-2606	5a. AGE—Last Birthday (Years): 52	5b. UNDER 1 YEAR (Months, Days) / 5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Mo, Day, Yr): Jan. 25,1948
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN US ARMED FORCES? 1974	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): Community Hospital	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): Claudia Zyviec	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright Maintenance	12b. KIND OF BUSINESS/INDUSTRY: Iliana Machine & Manufacturing
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: St. John	13d. STREET AND NUMBER: 8798 Lantern Dr.
13e. ZIP CODE: 46373	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): N/A; College (1-4 or 5+): 3		

PARENTS

18. FATHER'S NAME (First, Middle, Last): Hilary Raab	19. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Graf

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Claudia Raab	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8798 Lantern Dr. St. John, IN46373	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 8, 2000 Regional Cremation Service	21c. LOCATION—City or Town, State: Munster, IN
22a. EMBALMER'S NAME: N/A	22b. EMBALMER'S LICENSE NO: N/A	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FD09200077	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Elmwood Chapel FHD#19900052 11300 97th Lane St. John, IN 46373

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. Lymphoma — Months

DUE TO (OR AS A CONSEQUENCE OF):
b.

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

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

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) —

FILED JUL 31 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: [signature]	29c. MEDICAL LICENSE NO: 01038072	29d. DATE SIGNED (Month, Day, Year): 6/6/00

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Robin 9305 Calumet Ave. Munster, In

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Williams MD — 32. DATE FILED (Month, Day, Year): June 7, 2000

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

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

JUN 07 2000 01810

Donald R. O'Dell
707 E. Commercial Ave.
P.O. Box 128 Lowell, In. 46356

Alejandro S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

900 EP 3865

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

25×10