This Document Not Valid
Unless Stamped on Reverse
Side and Embossed With
Raised Seal of Porter County

PORTER COUNTY
CERTIFICATE OF DEATH

Hold For MERIDIAN Title
Porter County
Health Department
1401 Calumet Avenue
Valparaiso, Indiana 46383

(7) 15864K00

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): FLOYD GORDON WIECHERT
2. SEX: Male
3a. TIME OF DEATH: 5:00A M
3b. DATE OF DEATH (Month, Day, Yr): November 30, 1995
4. SOCIAL SECURITY NUMBER: 311-28-1860
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): MAY 5, 1909
7. BIRTHPLACE (City and State or Foreign Country): SUPERIOR, WISCONSIN
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): FOUNTAINVIEW PLACE NURSING HM.
9c. CITY, TOWN, OR LOCATION OF DEATH: PORTAGE
9d. COUNTY OF DEATH: PORTER
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): RUTH ESTELLE THARP
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SWITCHMAN
12b. KIND OF BUSINESS/INDUSTRY: IN HARBOR BELT RR
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 3465 TEXAS ST
13e. ZIP CODE: 46405
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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ERNEST WIECHERT
19. MOTHER'S NAME (First, Middle, Maiden Surname): LEONA BERARD

INFORMANT

20a. INFORMANT'S NAME (Type/Print): RUTH WENDT
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7428 Mooresville, Indianapolis, In
20c. Relationship: Granddaughter

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): DEC 3, 1995 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER?: X ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Kenneth P. Stevens
24b. LICENSE NUMBER (of Licensee): FD08900027
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH19300009 REES FUNERAL HOME, BRADY CHAPEL 3781 CENTRAL AV, LAKE STATION, IN 4640

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. Cardiac Dysrhythmia	
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

FILED
AUG 2 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM?:
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

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Desai
29c. MEDICAL LICENSE NO: 01027933
29d. DATE SIGNED (Month, Day, Year): 12 1 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SHREYAS A. DESAI MD, 2640 HAMSTROM RD, PORTAGE, IN 46368

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary A. Babiuke MD
32. DATE FILED (Month, Day, Year): December 1, 1995

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, specify driver, passenger, pedestrian, etc.

2100 900 Ac

25 X

No. 483833

PORTER COUNTY HEALTH DEPT.
VALPARAISO, INDIANA
THIS IS TO CERTIFY THAT THIS IS A
TRUE COPY OF THE ORIGINAL RECORD.

Gary A. Babcock, MD
HEALTH OFFICER

25×