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NTION ESTATE: The Social Security # is requested by this state agency in order to its statutory responsibility. Disclosure is y and there will be no penalty for refusal.

No. 1742-00

Key # 7-28-43

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ..........................

STATE OF INDIANA
LAKE COUNTY

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

PRINT N ANENT K INK

| Field | Entry |
|---|---|
| 1 DECEASED—NAME (First Middle Last) | ALBERT J. VanSESSEN |
| 2 SEX | Male |
| 3a TIME OF DEATH | 3:30 A M |
| 3b DATE OF DEATH (Month Day Yr) | July 24, 2000 |
| 4 SOCIAL SECURITY NUMBER | 316-10-5198 |
| 5a AGE—Last Birthday (Years) | 82 |
| 5b UNDER 1 YEAR (Months Days) | |
| 5c UNDER 1 DAY (Hours Minutes) | |
| 6 DATE OF BIRTH (Mo Day Yr) | July 2, 1918 |
| 7 BIRTHPLACE (City and State or Foreign Country) | Hammond, Indiana |
| 8a WAS DECEDENT A U S VETERAN? | Yes |
| 8b YEAR LAST SERVED IN US 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) | 5303 West 101st Avenue |
| 9c CITY, TOWN, OR LOCATION OF DEATH | Crown Point |
| 9d COUNTY OF DEATH | Lake |
| 10 MARITAL STATUS (Specify) | Married |
| 11 SURVIVING SPOUSE (If wife, give maiden name) | Sarah J. Woodruff |
| 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) | Electrician |
| 12b KIND OF BUSINESS/INDUSTRY | Continental Electric |
| 13a RESIDENCE—STATE | Indiana |
| 13b COUNTY | Lake |
| 13c CITY TOWN OR LOCATION | Crown Point |
| 13d STREET AND NUMBER | 5303 West 101st Avenue |
| 13e ZIP CODE | 46307 |
| 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? (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+) | |
| 18 FATHER'S NAME (First Middle Last) | Bert VanSessen |
| 19 MOTHER'S NAME (First Middle Maiden Surname) | Elizabeth Winterhoff |
| 20a INFORMANT'S NAME (Type/Print) | Sarah VanSessen |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 5303 W 101st, Crown Point, IN 46307 |
| 20c Relationship | Wife |
| 21a METHOD OF DISPOSITION | ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) |
| 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | July 29, 2000 Chapel Lawn Memorial Gardens |
| 21c LOCATION—City or Town, State | Schererville, Indiana |
| 22a EMBALMER'S NAME | Amy DeMunck |
| 22b EMBALMER'S LICENSE NO | FI29900059 |
| 23 WAS DEATH REPORTED TO CORONER? | XX No ☐ Yes |
| 24a SIGNATURE OF FUNERAL DIRECTOR | [signature] |
| 24b LICENSE NUMBER (of Licensee) | 1009893 |
| 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME | PRUZIN & LITTLE FUNERAL SERVICE #3001261 811 E Franciscan Dr, Crown Point, IN 46307 |

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 | Renal Failure | 1-2 wks |
| DUE TO (OR AS A CONSEQUENCE OF): b | Hypercalcemia | 1 month |
| Conditions if any which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF): c | Chronic Myelogenous Leukemia | 2 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): d | | |

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: COPD, Colitis

| Field | Entry |
|---|---|
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM | 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) | -- |

29a CERTIFIER (Check only one)
XX 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) as stated

| Field | Entry |
|---|---|
| 29b SIGNATURE AND TITLE OF CERTIFIER | J.A. Kacmar, M.D. |
| 29c MEDICAL LICENSE NO | 27058 |
| 29d DATE SIGNED (Month Day Year) | 7/24/00 |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) | Joseph A. Kacmar M.D., 123 N. Court Street, Crown Point, IN 46307 |
| 31 HEALTH OFFICER'S SIGNATURE | Alexander S. Williams MD |
| 32 DATE FILED (Month Day Year) | Jul 27 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. | |

FILED SEP 2 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

THIS CERTIFICATE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUL 27 2000
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

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

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