

STATE OF FLORIDA

OFFICE of VITAL STATISTICS
CERTIFIED COPY

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO. 351

CERTIFICATE OF DEATH
FLORIDA

1 DECEASED'S NAME: FIRST Gustave, MIDDLE Adolph, LAST Carlson, SEX Male

3 DATE OF DEATH (Month, Day, Year) January 22, 1996

4 SOCIAL SECURITY NUMBER 306-09-1879

5a AGE Last Birthday (Years) 80

5b UNDER 1 YEAR: Months 0, Days 0

5c UNDER 1 Day: Hours 0, Minutes 0

6 DATE OF BIRTH (Month, Day, Year) July 2, 1915

7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana

8 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No

9a PLACE OF DEATH (Check only one - see instructions on other side): HOSPITAL Inpatient, Outpatient, DOA, OTHER - Nursing Home, Residence, Other (Specify)

9b INSIDE CITY LIMITS? (Yes or No) Yes

9c FACILITY NAME (if not institution, give street and number) Cape Coral Hospital

9d CITY, TOWN, OR LOCATION OF DEATH Cape Coral

9e COUNTY OF DEATH Lee

10a DECEASED'S USUAL OCCUPATION Supervisor

10b KIND OF BUSINESS/INDUSTRY Steel Mill

11 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married

12 SURVIVING SPOUSE (if wife, give maiden name) Vera Coblentz

13a RESIDENCE - STATE Indiana

13b COUNTY Lake

13c CITY, TOWN, OR LOCATION Merrillville

13d STREET AND NUMBER 5360 Buchanan Street

13e INSIDE CITY LIMITS? (Yes or No) Yes

13f ZIP CODE 46410

14 WAS DECEASED OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Mexican, Cuban, Mexican Puerto Rican, etc.) No

15 RACE - American Indian, Black, White, etc. (Specify) White

16 DECEASED'S EDUCATION (Specify only highest grade completed) 5+

17 FATHER'S NAME (First, Middle, Last) Eric Carlson

18 MOTHER'S NAME (First, Middle, Maiden Surname) Karen Karlson

19a INFORMANT'S NAME (Type, Print) Vera Carlson

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5360 Buchanan Street Merrillville, Indiana 46410

20a METHOD OF DISPOSITION: Burial, Cremation, Removal from State

20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Ridge Lawn Cemetery

20c LOCATION - City or Town, State Gary, Indiana

21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH [Signature]

21b LICENSE NUMBER (of Licensee) 4072

21c NAME AND ADDRESS OF FACILITY Metz Funeral Home, 1306 Lafayette Street, Cape Coral, Florida 33904

22a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. (Signature and Title) [Signature]

22b DATE SIGNED (Mo., Day, Yr) 1/24/96

22c HOUR OF DEATH 11:37 A.M.

22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

23a 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. (Signature and Title) [Signature]

23b DATE SIGNED (Mo., Day, Yr)

23c HOUR OF DEATH

24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) James A. Conrad, M.D., 8540 College Parkway, Fort Myers, Florida 33919

25a SUBREGISTRAR - SIGNATURE AND DATE [Signature]

25b LOCAL REGISTRAR - SIGNATURE [Signature]

25c DATE REGISTERED Jan 29 1996

26 PART I: Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hepatic failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) Pneumonia

Sequitely list conditions if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.

26 PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27a WAS AN AUTOPSY PERFORMED? (Yes or No) No

27b WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? (Yes or No) No

28 CASE REFERRED TO MEDICAL EXAMINER? (Yes or No) No

29 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? YES NO

30a IF SURGERY IS MENTIONED IN PART I OR II, ENTER CONDITION FOR WHICH IT WAS PERFORMED.

30b DATE OF SURGERY (Mo., Day, Yr)

30c TIME OF SURGERY

30d INJURY AT WORK? (Yes or No)

30e DESCRIBE HOW INJURY OCCURRED PETER BENJAMIN LAKE COUNTY AUDITOR

31 PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined

32a DATE OF INJURY (Month, Day, Year)

32b TIME OF INJURY M

32c PLACE OF INJURY - At home, farm, street, factory, etc. (Specify)

32d LOCATION (Street and Number or Rural Route Number, City or Town, State)

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

BY Mary Lou Holley Jan. 29, 1996 State Registrar 02403

Meadowdale Subdiv. lot 15 Block 8
Key # 15-271-15
Unit # 8

STATE OF INDIANA
LAKE COUNTY
FILED
OCT 31 PM 1:20
RECORDED



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CERTIFICATION OF VITAL RECORD