62-289326
* 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. 2249-02

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased—Name (First, Middle, Last)	HAROLD F. BEALS
2. Sex	Male
3a. Time of Death	11:00 PM M
3b. Date of Death (Month, Day, Yr)	June 10, 2002
4. *Social Security Number	311-26-0538
5a. Age—Last Birthday (Years)	72
5b. Under 1 Year (Months / Days)	
5c. Under 1 Day (Hours / Minutes)	
6. Date of Birth (Mo, Day, Yr)	October 4, 1929
7. Birthplace (City and State or Foreign Country)	Niles Ohio
8a. Was Decedent a U.S. Veteran?	YES
8b. Year Last Served in U.S. Armed Forces?	1953
9a. Place of Death (Check only one)	Hospital: [X] Inpatient [ ] ER/Outpatient [ ] DOA; Other: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. Facility Name	St. Mary Medical Center
9c. City, Town, or Location of Death	Hobart
9d. County of Death	Lake
10. Marital Status	Widowed
11. Surviving Spouse (If wife, give maiden name)	N/A
12a. Decedent's Usual Occupation	Construction
12b. Kind of Business/Industry	Construction
13a. Residence—State	IN
13b. County	Lake
13c. City, Town, or Location	Hobart
13d. Street and Number	108 S. Wabash Street
13e. Zip Code	46342
13f. Inside City Limits	[ ] No [X] Yes
13g. On a Farm?	[X] No [ ] Yes
14. Citizen of What Country?	U.S.A.
15. Was Decedent of Hispanic Origin?	[X] No [ ] Yes
16. Race	White
17. Decedent's Education — Elementary/Secondary (0-12)	12
17. College (1-4 or 5+)	

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	Hugh Beals
19. Mother's Name (First, Middle, Maiden Surname)	Mary Shafer

INFORMANT

Field	Value
20a. Informant's Name	Russell Beals
20b. Mailing Address	320 West 700 North, Valparaiso, IN 46385
20c. Relationship	Son

DISPOSITION

Field	Value
21a. Method of Disposition	[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. Date and Place of Disposition	Jun 13, 2002 Calumet Park Cemetery
21c. Location—City or Town, State	Merrillville IN
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	James J. Krause (signature)
24b. License Number (of Licensee)	FD01006463
25. Name, Address, and License Number of Funeral Home	Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

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. Chronic Obstructive Lung Disease

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

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?	28a. Was an Autopsy Performed?	28b. Were Autopsy Findings Available Prior to Completion of Cause of Death?
No	No	No

CERTIFIER

29a. Certifier (Check only one)
[X] 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	29c. Medical License No.	29d. Date Signed (Month, Day, Year)
(signature)	01023053	6/11/02

30. Name and Address of Person Who Completed Cause of Death (Item 26): John E. Carter MD 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. Health Officer's Signature: (signature) D.O.

32. Date Filed (Month, Day, Year): June 12, 2002

FILED NOV 7 2002 PETER BENJAMIN LAKE COUNTY AUDITOR 000542

33. Manner of Death	34a. Date of Injury	34b. Time of Injury	34c. Injury at Work?	34d. Describe How Injury Occurred
[X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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.:

11.00 ZP

SDH06-004 State Form 10110 (R5/1-99)

CT

LEGAL DESCRIPTION

Lot 2, in Stan's Subdivision, in the City of Hobart, as per plat thereof, recorded in Plat Book 67 page 55, in the Office of the Recorder of Lake County, Indiana.