

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1476-95

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

PARENTS

INFORMANT

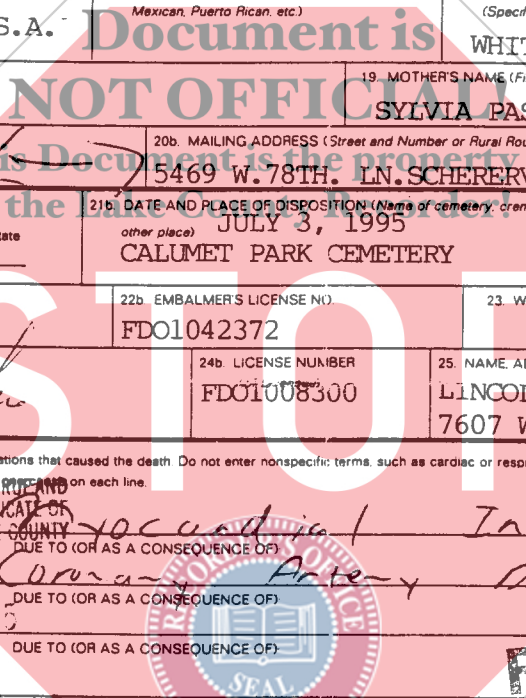
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) FREDERICK HIGUET		2. SEX MALE	3a. TIME OF DEATH 10:20A M	3b. DATE OF DEATH (Month, Day, Yr) JUNE 30, 1995	
4. *SOCIAL SECURITY NUMBER 306-38-9150	5a. AGE—Last Birthday (Years) 57	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) APRIL 9, 1938	
7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO, INDIANA		8a. WAS DECEDENT A U.S. VETERAN? YES			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1958		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) BROADWAY METHODIST HOSPITAL		9c. CITY, TOWN, OR LOCATION OF DEATH MERRILLVILLE	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) ERNESTINE BRYANT	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 STEEL INDUSTRY	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION SCHERERVILLE	13d. STREET AND NUMBER 5469 W. 78TH. LN.		
13e. ZIP CODE 46375	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16. RACE—American Indian, Black, White, etc. (Specify) WHITE	
18. FATHER'S NAME (First, Middle, Last) GILBERT HIGUET		19. MOTHER'S NAME (First, Middle, Maiden Surname) SYLVIA PASTERNAK			
20a. INFORMANT'S NAME (Type/Print) ERNESTINE HIGUET		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5469 W. 78TH. LN. SCHERERVILLE, IND. 46375	20c. Relationship WIFE		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) JULY 3, 1995 CALUMET PARK CEMETERY		21c. LOCATION (City or Town, State) MERRILLVILLE, INDIANA	
22a. EMBALMER'S NAME CHARLES WELLS		22b. EMBALMER'S LICENSE NO. FDO1042372	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eli Taylor</i>		24b. LICENSE NUMBER FDO1008300	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IND. 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, etc. Do not enter on each line. LET A COPY OF THE CERTIFICATE OF DEATH BE FILED WITH THE LAKE COUNTY HEALTH DEPT.					
IMMEDIATE CAUSE OF DISEASE OR CONDITION RESULTING IN DEATH Coronary Artery Disease			Approximate Interval Between Onset and Death Seconds		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last JUL 05 1995			YEARS		
PART II. Other significant conditions contributing to the death but not previously stated in Part I LAKE COUNTY HEALTH COMMISSIONER					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) 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) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 PETER BENJAMIN LAKE COUNTY AUDITOR			
29c. MEDICAL LICENSE NO. 02000872		29d. DATE SIGNED (Month, Day, Year) 7-5-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John A. Hoehn, D.O. 2001 US Hwy 41, Suite L Schererville, IN 46375					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams MD</i>			32. DATE FILED (Month, Day, Year) July 5, 1995		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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) 001577			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



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