

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

(10 + 2)
INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1548-00

CERTIFICATE OF DEATH

State No.

384823

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED - NAME (First, Middle, Last) Joseph H. Heath		2. SEX Male		3a. TIME OF DEATH 3:30 PM		3b. DATE OF DEATH (Month, Day, Yr.) July 03, 2000	
4. * SOCIAL SECURITY NUMBER 401-32-9511		5a. AGE - Last Birthday (Years) 71		5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____	
6. DATE OF BIRTH (Mo., Day, Yr.) January 01, 1929		7. BIRTHPLACE (City and State or Foreign Country) McCroary Arkansas					
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? Unknown		PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____			
9b. FACILITY NAME (If not institution, give street and number) St. Anthony Medical Center				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) Katie Croney		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Chemist		12b. KIND OF BUSINESS/INDUSTRY Steel	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Cedar Lake		13d. STREET AND NUMBER 6913 West 128th Lane	
13e. ZIP CODE 46303		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12 College (1-4 or 5+) 4					
18. FATHER'S NAME (First, Middle, Last) Joseph Heath				19. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Fraze			
20a. INFORMANT'S NAME (Type/Print) Katie Heath				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 West 128th Lane, Cedar Lake, IN		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 7, 2000 Calumet Park Cemetery		21c. LOCATION - City or Town, State Merrillville, Indiana			
22a. EMBALMER'S NAME Raymond E. White Jr.		22b. EMBALMER'S LICENSE NO. FD08700086		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Raymond E. White Jr.</i>		24b. LICENSE NUMBER (of Licensee) FD08700086		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana			
28. 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. Multiple Myeloma!							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): _____ b. 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? (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) 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 R S Drasga				29c. MEDICAL LICENSE NO. 01031484		29d. DATE SIGNED (Month, Day, Year) 07-05=2000	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) DR RAY DRASGA 8127 MERRILLVILLE IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>							
32. DATE FILED (Month, Day, Year) July 5, 2000							
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 THIS CERTIFIES THE ABOVE IS TRUE AND CORRECT AND THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT		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) MAY 24 2004			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. STEPHEN R. STIGLICH LAKE COUNTY AUDITOR					

DECEDENT

PARENTS

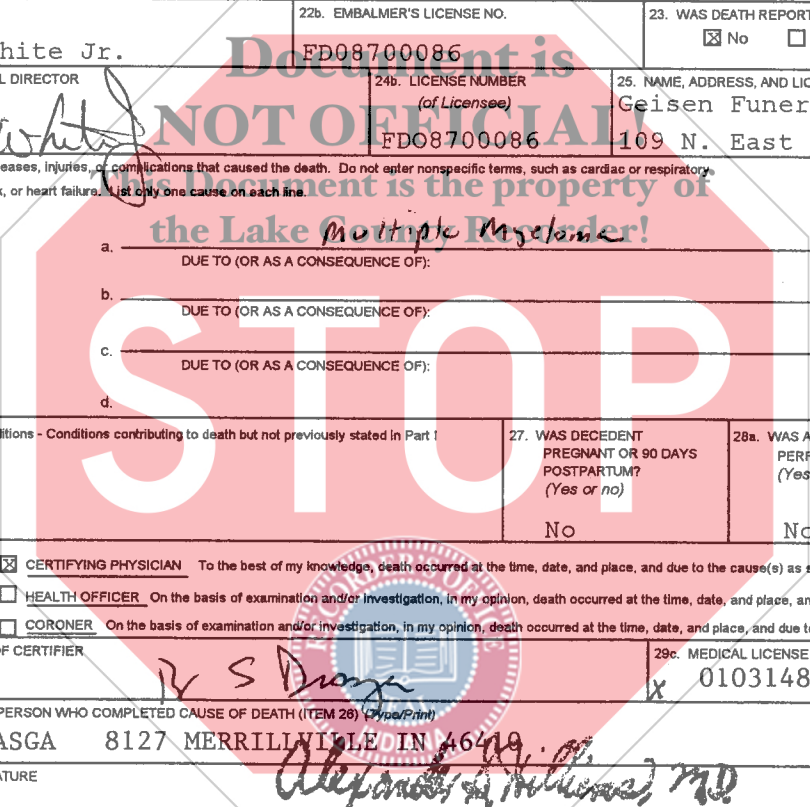
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



Unit # 31
Key # 25-77-15
Highgrove and Add. lots 14, 15, 16, 17 Block 13

13810 Delaware St.
Crown Point, IN 46307

Sandra Hultz
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

2000 JUL 03 10 26 AM

FILED